

***United States Court of Appeals  
for the Second Circuit***



**APPELLEE'S BRIEF**





To be argued by  
ERIC NEISSER

77-2095

UNITED STATES COURT OF APPEALS  
FOR THE SECOND CIRCUIT

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LOUISE TODARO, ERNESTINE DAVIS, DEIDRA PLAIR,  
PHYLLIS KLIPPEL, SYLVIA DAVIS, CLEO BACON, IRIS  
CAPELLA, NAOMI BOSTICK, MARY REED, ALICE TAVER, :  
CAROL LEWIN, TAMMY GOLSTON, MARGARET GATLING, TONYA  
JACKSON, TRACYE CRAIG, BEVERLY MASSEY, CARMEN  
GARCIA, HELEN LAVORE, GLORIA TAGGART, MARTA HARDEE, :  
ALTHEA McDANIEL, RUTH DOBSON, MADELINE PINEDA, JUDY  
WHEAT, BERNADETTE BROWN, and EVELYN THORPE, on  
behalf of themselves and all other persons similarly :  
situated,

Plaintiffs, :

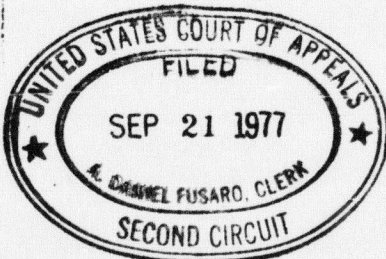
-against-

#77-2095

BENJAMIN WARD, Commissioner of the New York State  
Department of Correctional Services; IAN LOUDON,  
Assistant Commissioner for Health Services of the :  
New York State Department of Correctional Services;  
DAVID FROST, Southern Regional Director of Health  
Services of the New York State Department of :  
Correctional Services; JANICE WARNE, Superintendent  
of Bedford Hills Correctional Facility; HENRY  
WILLIAMS, Health Services Director of Bedford Hills :  
Correctional Facility; ROBERT TSCHORN, Surgical  
Consultant at Bedford Hills Correctional Facility;  
and MARIE DALY, Nurse Administrator at Bedford Hills :  
Correctional Facility, individually and in their  
official capacities, :

Defendants. :

-----X  
APPELLEES' BRIEF



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### QUESTIONS PRESENTED

I. WHETHER THE DISTRICT COURT ERRED IN CONCLUDING ON THE RECORD BEFORE IT THAT DEFENDANTS' SYSTEM OF MEDICAL CARE IS SO SERIOUSLY INADEQUATE AS TO CAUSE UNWARRANTED SUFFERING BY THE PLAINTIFF CLASS IN VIOLATION OF THEIR CONSTITUTIONAL RIGHTS.

II. WHETHER THE DISTRICT COURT EXCEEDED ITS AUTHORITY IN ENTERING A JUDGMENT WHICH, WITHOUT IN ANY WAY INTERFERING WITH THE PROFESSIONAL MEDICAL DISCRETION OF DEFENDANTS' HEALTH STAFF, ADDRESSES THE PROCEDURAL DEFICIENCIES AT BEDFORD HILLS PROVEN TO RESULT IN UNCONSTITUTIONAL DEPRIVATION OF MEDICAL CARE.

### STATEMENT OF THE CASE

This is an appeal by defendants from a Judgment of the United States District Court for the Southern District of New York (Ward, J.) entered on July 11, 1977, declaring certain aspects of the medical care system at Bedford Hills Correctional Facility ("Bedford Hills") unconstitutional, and enjoining defendants from subjecting the plaintiffs class, female prisoners serving sentences imposed by the New York State courts, to these practices.

This is a civil rights action, brought pursuant to 42 U.S.C. §1983, and commenced in the District Court on October 18, 1974. The plaintiffs sought declaratory and injunctive relief against defendant state prison officials' continuation of a broad range of health care practices and conditions at Bedford Hills, alleging



violations of the eighth and fourteenth amendments to the United States Constitution. Specifically, plaintiffs challenged the inadequate medical admissions processing, denial of access to necessary medical attention, denial of prescribed medical treatment and inadequate infirmary facilities.

This case was declared a class action on March 10, 1975. Trial commenced on January 12, 1976 and continued for fifteen days, ending on February 9, 1976. On April 25, 1977, the Court rendered its opinion.\* The Court analyzed in detail the extensive factual material presented at trial and found that defendants knowingly exposed the plaintiff class to risk of harm by using an inadequate and potentially dangerous X-ray machine (Opinion at A16); that the sick call system utilized by defendants was inadequate and systematically caused substantial delays or outright denials of access to a physician (Opinion at A23); that medical treatment prescribed by doctors, specifically the performance of diagnostic tests (Opinion at A25 and A30), the follow-up of abnormal test results (Opinion at A26), and the scheduling of follow-up

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\* The opinion is reported at 431 F. Supp. 1129, and is included in the Appendix. Citations to the Appendix are preceded by "A".

\*\* The trial transcript in this case is 2000 pages long, and over 150 exhibits were introduced into evidence which total at least an additional 4000 pages. The District Court noted that while the opinion, for brevity's sake, mentions only a few typical instances of denial of each medical deprivation, its findings are supported by a large number of similar examples in the record, all of which were considered by the Court. (Opinion at A13-14).



appointments ordered by the doctors (Opinion at A27) was not performed at all or was significantly delayed on a systematic basis; and that patients in the "sick wing" or infirmary were routinely denied necessary medical observation and communication (Opinion at A17). These conditions were found to violate plaintiffs' constitutional rights. Based on its findings, the Court ordered counsel for the parties to meet and try to seek agreement on

new means and procedures for:

1. Providing better access to medical providers by inmates in sick wing;
2. Conducting sick call which provides adequate nurse screening and reasonably prompt access to a physician;
3. Insuring that ordered laboratory work is reported and followed-up and medical reappointments are scheduled;
4. Periodic self-audits of the performance of the medical care delivery system, and record keeping procedures conducive to such audits. (Opinion at A37).

However, no agreement could be reached, and both parties submitted proposed judgments to the Court.\* On July 11, 1977, the Court entered a Judgment which differed significantly from both orders proposed by the parties.\*\* The Judgment was stayed by Judge Ward

See, Judgment, A 48; Plaintiffs' Proposed Judgment, A50; Defendants' Proposed Judgment, A 61. Defendants' Proposed Judgment provided for a moratorium on enforcement of all substantial terms of the order unless and/or until substantial increases in staffing and budget were obtained. (A at 67-68.)

\*\* For example, the Court rejected the time limits proposed by plaintiffs for sick wing rounds, access to a physician and follow-up on laboratory results, and substituted substantially longer time periods. The requirements to be met before an inmate is placed in a locked room in sick wing are considerably less stringent (footnote cont'd on next page)



until August 5, 1977 to permit defendants to apply to this Court for further relief. A notice at appeal was filed on August 2, 1977, and this Court extended the stay during the pendency of the appeal.

#### STATEMENT OF FACTS

##### I. INTRODUCTION

Plaintiffs called ten witnesses, five prisoners and five experts. The prisoner witnesses were Yvonne Lee, Mary Ledgister, Phyllis Hapeman Huber, Theresa Durante and Ann Galloway.

Plaintiffs' expert witnesses were Dr. Richard Della Penna, Medical Director of the Montefiore Hospital Health Service at Rikers Island, Assistant Professor of Social Medicine and Medicine at Albert Einstein School of Medicine, Chairman of the American Public Health Association's Committee for Standards Development for Jails and Prisons, and formerly Hospital Director of the

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(footnote cont'd)

than those proposed by plaintiffs, and the observation afforded inmates in locked rooms is reduced. Although plaintiffs argued for the necessity of having the physician appointment schedule made by the same nurse who does the screening, and thus is familiar with the condition of the inmates and can set reasonable priorities, the Judgment permits different personnel to conduct the screening and draw up the appointment list. Plaintiffs' proposal that all abnormal laboratory test results be reviewed by a doctor on the date received was rejected, and only those "significantly outside the laboratory's normal range" require this prompt review. Record keeping is less complete than plaintiffs requested. Defendants are required to do significantly less comprehensive auditing of the medical care system than plaintiffs proposed, and the Court permitted the auditing to be done by defendants' own personnel, without Court approval, rather than mandating auditors not employed by the Department as requested by plaintiffs.



Massachusetts Correctional Institution at Norfolk, Massachusetts (T599-602);\* Dr. Jonathan Weisbuch, Director of Health Services, Massachusetts Department of Correction, and former Associate Professor of Medicine at Boston University School of Medicine (T543-44); Dr. Patricia Nolan, a Board-certified public health physician with the Bureau of Ambulatory Care, New York City Department of Health, whose duties include the evaluation of various ambulatory care facilities within New York City as well as all New York City prison health facilities (T444-45); Dr. H. Joan Waitkevicz, internist and attending physician in general ambulatory medicine at three New York City institutions, Lincoln Hospital, St. Mark's Clinic and the People's Health Center (T228-30); and Laurel Rans, a professional consultant in correctional management, Vice Chairman of the American Bar Association National Resource Center on Women Offenders, and formerly Superintendent of the Iowa Women's Reformatory (T886-89).

Defendants called ten witnesses, all employees of the Department of Correctional Services: Marie Daly, Nurse Administrator at Bedford Hills; Dr. David Frost, the Department's Southern Regional Health Services Director; Dr. Henry Williams, Facility Health Services Director at Bedford Hills; Dr. Iraj Saadat, consulting physician in obstetrics and gynecology at Bedford Hills; Bryan Boss, senior correction counselor at Bedford Hills; Margaret Rivenburgh, correctional sergeant at Bedford Hills; Eugene Gladwin,

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\* Numbers in parentheses preceded by "T" refer to pages of the trial transcript.



budget analyst at Bedford Hills; Karen Vagianos, laboratory technician at Bedford Hills; Frieda Collins, correction officer at Bedford Hills; and Ida Geser, nurse at Bedford Hills.

Plaintiffs introduced 125 exhibits in evidence, and defendants introduced 36 exhibits.\* The exhibits include the prison medical records of 64 inmates,\*\* as well as a detailed summary of these records prepared by Dr. Waitkevicz after close review of them. (The summary was introduced in evidence as Ex. 67, and is included in the Appendix at A 69.) In addition, various medical records and logs maintained at Bedford Hills such as admission books, various lobby clinic notebooks, and various doctors' appointment books were introduced. Also included in the record are portions of depositions of medical personnel at Bedford Hills, defendants' answers to interrogatories, various

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\* A complete list of the exhibits is included in the index to the record on appeal.

\*\* The defendants asserted at trial, and continue to argue on this appeal, that the sixty-four inmate medical records are not a representative sample. However, as the District Court noted:

Although not a random sample in a statistical sense, the records were not pre-selected by plaintiffs' attorneys. Rather, what was introduced was limited by this Court's discovery order issued in response to the defendants' resistance to broader discovery. If the records introduced by plaintiffs were atypical, defendants were free to introduce other records, provided appropriate measures were taken to protect inmate privacy. This they failed to do, and so the Court deems the records produced by plaintiffs to be representative of the medical treatment provided to the plaintiff class. (Opinion at A13.)

(footnote cont'd on next page)



memoranda of Dr. Frost and other supervisory personnel, the reports of several agencies concerning the operation of the medical system at Bedford Hills, and forty photographs of the medical facilities at Bedford Hills.

## II. BACKGROUND FACTS

As the District Court noted, prison health care must be adjudicated in terms of the uniqueness of the prison setting. Because they are imprisoned, plaintiffs are totally dependent upon prison officials for all of their medical needs, "from treatment for minor, routine instances of illness to more esoteric specialty care." (Opinion at A10.) As a consequence of this dependence, the District Court found that demands on a prison health care system are inevitably, and legitimately, substantial. In addition to plaintiffs' dependence on defendants for such routine care as treatment for headaches, upset stomachs, or colds, the Court found "a higher incidence of medical problems among prisoners than in a similarly aged unincarcerated population,"\* and

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(footnote cont'd)

Indeed, given defendants' misleading claim that plaintiffs had easy access to other records (Brief at 54-55), it is important to note that because of defendants' objections to discovery, plaintiffs were denied access to medical records, even of named plaintiffs, until the District Court's discovery order of March 10, 1975; that again in response to defense objections the notice to the class was only posted for thirty days; and that after October 10, 1975, plaintiffs were not permitted to request any additional records.

\* Dr. Weisbuch, Director of Health Services for the Massachusetts Department of Correction, testified that prisoners have a higher incidence of epilepsy, tuberculosis, ulcers and diabetes, among other diseases, than a similarly aged group of unimprisoned people. (T549-50.) See also Nclan, T464; Rans, T928.



noted that "one factor which repeatedly impressed the court as it reviewed plaintiffs' medical records was the extent to which Bedford Hills inmates suffered from serious medical conditions." (Opinion at A10-11.) Indeed, among the sixty-four typical medical charts introduced by plaintiffs were cases of diabetes, suspected and actual cancer, epilepsy, glaucoma and other diseases which damage vision, and hypentension.

While prisoners thus depend upon their keepers for all medical services, the nature of imprisonment, with its overwhelming emphasis on custody and security, creates a constant danger that the delivery of medical care will be compromised. For example, plaintiffs cannot move freely about the institution and thus cannot get to see a doctor unless they are summoned by defendants. (T133, 1907-08.)\* The medical staff is limited as to the time and place in which it may provide medical care (T1479-80; Ex. 87, pp. 83-84), and security precautions are necessary at medical encounters. (T26, 1452.) Accordingly, a tightly structured system of access and delivery must be developed so that necessary medical care will be readily available. Della Penna, T604; Nolan, T464; Weisbuch, T551.

Having thus noted the nature of health care delivery in prisons, the Court turned to a consideration of the medical procedures and system in effect at Bedford Hills.

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\* Prisoners are not permitted to move around the prison freely, and must get a pass from an officer before going to the medical building or face disciplinary action. (T133, 36-40.)



### III. X-RAY MACHINE

As part of admissions processing, a chest x-ray is taken of every new inmate at Bedford Hills. (T839, 865.) Thereafter, additional chest x-rays of all class members are required every year. (Ex. F.) Defendants use an old and dangerous x-ray machine which subjects the women at Bedford Hills to risk of overexposure to radiation. As early as the fall of 1973, defendants were aware that the x-ray machine was antiquated and needed replacement. In April of 1974, inspectors from the New York State Department of Health reported to defendants that the machine was not in compliance with minimum state standards because it exceeded permissible radiation exposure limits and irradiated the entire body rather than just the chest.\* At the suggestion of the New York State Comptroller whose audit found the old machine frequently overheating (Ex. 116, pp. 24-25), a new x-ray machine was transferred to Bedford Hills in the fall of 1975. (T1436.) However, the new machine was still not in use as of the time of trial in February, 1976 because defendants had not obtained a table of the right thickness to place it on. (Opinion at A16; T841-42, 1436-37.)

The court found that knowing and continued use of a dangerous and inadequate x-ray machine showed deliberate indifference to

\* Ex. 91, p. 1; Ex. 126, pp. 11-12, 26; Ex. 127, pp. 11-12; Inspection Report of Bureau of Radiological Health, New York State Department of Health, April 5, 1974, p. 1-items 5, 10d, 10e, 13; p. 2 - items 5, 12, 13 and Remarks, Appendix 3 to defendants' Supplemental Answer to First Set of Interrogatories; Nolan, T513-14; Della Penna, T655; Exs. 78q and 78r.



plaintiffs' well-being.\* The Court accordingly ordered that plaintiffs not be exposed to any x-ray machine at Bedford Hills which does not meet state standards and has not been inspected and certified by the appropriate state agency. The order requires that any x-ray machine in use which has not been inspected and certified within ninety days prior to the judgment be inspected within thirty days, that it be reinspected thereafter at intervals established by state regulations, and that plaintiffs' counsel receive copies of all inspection reports concerning x-ray machines at Bedford Hills for three years. (Judgment, ¶I. A-C, A at 40.)\*\*

\* Plaintiffs also charged that defendants routinely expose them to unnecessary risk by routinely taking all urine samples by the process of catheterization, a practice condemned by experts because of its risk of infection. (T476, 618.) Because defendants terminated this long-standing practice shortly before trial, the District Court did not rule on this issue. (Opinion at A16.)

\*\* Plaintiffs also challenged delays in performing admission physical examinations, which were to be done the day following a new inmate's arrival or as soon thereafter as possible (Opinion at A14; Ex. E), but actually were greatly delayed. During the two-year period ending in September, 1975, general admission physical examinations were delayed 43 days on the average, and gynecological exams 27 days; in some months, the average delays was as much as 129 days. (Ex. A to Ex. 68, pp. 2, 4; Ex. O.) Many newly admitted women apparently received no physical examination, for there was no notation after their names in defendants' Admission Book, where such examinations are recorded, to show that a physical was performed. (Ex. O, Ex. FF, T1312.) See Fed. R. Evid. §803(7) (absence of entry in regularly maintained records as evidence of nonoccurrence of event). The District Court found, however, that the denial of medical care caused by these delays was actually a part of the larger problem of access to a physician, discussed below at 11-26.



#### IV. PHYSICIAN ACCESS - THE LOBBY CLINIC

Denial of access to a physician for necessary medical care is a problem which pervades the medical care system at Bedford Hills. The Court found that women who presented significant medical problems upon admission to the prison, or who developed them soon after admission, were frequently not seen by doctors for two weeks to two months. (Opinion at A20.) Even lengthier delays are not unusual. (See below at 19, 23.) This problem occurs repeatedly for all prisoners at Bedford Hills who seek access to medical care, causing inevitable suffering. The Court found that systemic problems in the defendants' lobby clinic screening process were the cause of these failures to provide adequate medical treatment. (Opinion at A23.)

The "lobby clinic" is a small room located in the lobby of one of the three residence buildings at Bedford Hills. (T793.) The room contains two storage cabinets, a table and a chair. (T794; Ex. 78e.) No medical equipment is available, except the few supplies (thermometer, bandages, etc.) which the nurse carries with her (T872, 1926), nor are the inmates' medical records available (T1463-64). When the clinic is open,\* a single nurse is stationed inside the clinic room, separated from the patients by a locked door with a barred, cashier's type window. (Opinion at A21; T25, 483, 628, 1926; Ex. 78d.) All women in the prison who

\* The lobby clinic is open twice a day, in the early morning and again in the evening, for approximately an hour at a time. (Opinion at A18.)



are on regular doses of medication which are dispensed by the nurse,\* all women who have medical complaints for which they want to see the doctor, and all women who seek treatment by the nurse for minor ailments, or have inquiries about the results of laboratory tests or the scheduling of medical appointments, line up together at the lobby clinic door on a "first come, first served" basis. (T24-26, 128, 155-156, 187, 481-83, 488-89, 847, 873-75, 947-48, 1925; Ex. 117.) As each woman approaches the window in her turn, she gives her name and the purpose of her visit. (T948, 1925.) This is done wholly without privacy, in the presence of both the other women on the line and the correction officer stationed at the window.\*\* No examination of the woman is possible through the grated window. The line is noisy and chaotic, since women who are in a hurry seek to

\* The number of medication doseages given out at each lobby clinic has varied depending upon whether some women are being given a several days' supply of medication in bulk. Prior to September, 1975, when no medications were distributed in bulk, approximately 200 women were on line at each lobby clinic to receive medication. (T956-57.) When a bulk distribution system for some medications was introduced, the number was reduced to about 50. (T956-57; Ex. 86, pp. 21-21A.) Since trial, defendants have generally abandoned the bulk distribution system (see Memorandum in Support of Plaintiffs' Proposed Judgment, 16), and the number of women on line for medication at each lobby clinic has, in all likelihood, returned to the higher level.

\*\* Yet defendants' own doctor admitted concern about "the silent 90% who are not complaining....I want that shy, retiring youngster, who has a diabetic condition and who's ashamed because of one reason or another to say in the initial examination, I'm a diabetic, I want insulin. Ashamed to say it because she was taught it was a stigma or she feels something's wrong." (Ex. 86, p. 55.) See also, Della Penna, T630; Rans, T916-17.



shortcut the process by approaching the nurse while she is conversing with an inmate who has reached the window in her turn. (T25, 156-59, 916-17, 1454-55, 1953.) The Court found that the whole process, including the administration of medication and the nurse making a note of the encounter in her lobby clinic notebook (see, below at 15-16) takes approximately 15-20 seconds per inmate. (Opinion at A20.)

The nurses who operate the lobby clinic are supposed to follow the two-page "standing orders" established by the institution's doctors (Ex. 69; T1318, 1492; Ex. 98, p. 3); however, plaintiffs established through their expert witnesses that the standing orders which exist are too vague to provide real guidance to nurses, in some cases require medical diagnoses which should not be made by nurses and, in any case, are impossible to make in the lobby clinic as it currently exists. (T483-84, 501-03, 579-80, 593, 629, 638-40.) For example, the standing orders direct different treatment for boils if an "infection on eruption" is present; for earaches, the standing orders require an examination of the ear canal for inflammation before determining the proper course of treatment. Yet the physical examinations needed to follow these directions are impossible for the nurse to perform from behind a locked door with a barred window, and the Court found that a meaningful examination cannot be conducted because of the operational defects and physical limitations of the lobby



clinic.\* (Opinion at A21-22; Ex. 86, p. 23; T1462, 1925-26, 1954-55; Ex. 37, medical record of Evelyn Mann, nurse note of 9/14/75, "seen in p.m. clinic. [Complains of] pain, tenderness, swelling of L breast with 2 small painful nodules under L axilla. Unable to give breast exam because of clinic area...") In other instances, the standing orders require the nurse to know whether a patient has "hypertension", is an "epileptic", has "asthma", or had a tetanus shot in the last three years, before determining

\* The door is kept locked and inmates are not permitted to enter the lobby clinic room for security reasons, since supplies of various medications which the nurse is administering are in the room. Defendants asserted at trial, and continue to claim here, that women requiring closer examination are asked to step aside and wait until the end of the clinic session when they will be taken into the room individually. However, Ms. Geser, who is in charge of the lobby clinics and conducts them herself at least once a week (T807, 1462) explained that "in general we are not taking blood pressures, this type of thing, for the simple reasons that in the set-up they do not allow anyone in the room itself" and that "when the medications are all locked up, then we can get women down if somebody has to have a blood pressure taken or a dressing done...but in the general screening of morning clinic you don't bring them in the room for any great evaluation." (Ex. 86, p. 23.) See also T1927-29. But blood pressures are in fact rarely taken. See below at 29-30; see also Ex. 70g: in 20 consecutive morning clinics, not a single recorded blood pressure; Ex. 68, Exhibit C; Nolan, T486.) Yvonne Lee, who had regularly attended lobby clinic in the nine months prior to trial testified that she had never seen an inmate physically examined at lobby clinic and that inmates were only brought in the room for insulin injections. (T1954-55.) It is obvious then, that examinations within the clinic room are at best extremely infrequent occurrences, and the Court correctly found that this procedure touted by defendants "appears to be rarely used." (Opinion at A22, n.12.)

Ms. Daly indicated that the nurse might also choose to bring the woman down to the main ambulatory care clinic for further evaluation and screening. (T964-65.) However, Ms. Geser conceded that this, also, "doesn't happen too often" (T1946).



appropriate treatment. Yet the inmate's medical record, which contains this information, is not available to the nurse at the lobby clinic. (T955, 1464, 1931.) Some orders are too vague for application\* and none at all are provided for such common occurrences as abdominal pains, head injury or vision problems. Shortly before trial, a new order was issued which directs the nurse, apparently in every case, to take the history of the complaint, the patient's temperature, pulse, respiration, and blood pressure and perform a "simple exam." It further specifies instances when a physician referral is expected. However, no change was made in the physical setting of lobby clinic to permit such examinations or blood pressure measurements.\*\* (Compare Ex. 86, p. 23 and T1927-29; see also T1952-55.)

The nurse at the lobby clinic has with her a small notebook in which she may note the name of a woman who has approached her with a physical complaint or a question. The lobby clinic notebooks\*\*\* are small school-composition type notebooks. (Exs. 70a

\* See, e.g. "Nerves", "Muscular". Others list two possible actions, one of which is a doctor's appointment, but do not explain whether both actions are required or when a physician referral is appropriate. See, e.g., "Genito-Urinary", "Hemorrhoids", Ex. 69.

\*\* Dr. Williams, who issued the new order, had never attended the lobby clinic or even seen the room where the clinic is held, nor had Dr. Frost, his supervisor, ever attended a lobby clinic. (T 1375, 1684-85; Opinion at A23.) They were thus apparently unaware that the examinations required by the standing orders could not in fact be done.

\*\*\* Several different lobby clinic notebooks are used, one by the morning clinic nurses and others by the individual nurses who staff the evening clinic on various evenings. (T1464, 1934, 485; Opinion at A22.)



through 72j), and the notations made by the nurse are typically undated, in pencil, and extremely brief and cryptic. Commonly, there is only a list of names and a one or two word description of the problem, e.g. "stomach pains", "headache," "eye red," "asthma pill?"; sometimes only the inmate's name, or a notation "Dr." or "M.D.", indicating a physician referral, appears. (Ex. 68, p. 2-4; T484-85, 1465; Opinion at A22.) These minimal notes\* are used by the nurse, following the lobby clinic, to draw up a list of persons who ask to see the doctor. The nurse does not differentiate between cases she thinks are more or less urgent. (Opinion at A22; Ex. 84, pp. 50-52; T1007.) Such a list is drawn up by each of the five or six nurses who staff the two daily sessions of lobby clinic each week, and the lists are turned over to another nurse, Ms. Geser, who, based on the lobby clinic notes and lists, determines priorities and schedules medical appointments for the available physician time, entering them in the Doctors' Appointment Book. (Ex. 84, pp. 53-54, 58, 59-53; Ex. 86, pp. 37, 38, 41, 45; T1934; Opinion at A22.)

\* Defendants' characterization of the lobby clinic notebooks as providing "a running summary of the treatment provided" (Brief at 20), is not supported by the evidence. The extremely sketchy notes were considered by Ms. Daly, the nurse administrator, to be mere "reminders". (T1464.) Although Dr. Frost considered the notebooks "an important medical record", (T1381), neither he nor Dr. Williams had ever even seen them. (T1381, 1689.) Furthermore, based on examination of the lobby clinic notebooks themselves and an analysis of inmates' medical records and the lobby clinic process, the Court concluded that "not all inmate medical requests are even noted in the lobby clinic notebooks" and that the notebooks are "grossly inadequate". (Opinion at A22, 23.)



Important notations made by the nurses in the lobby clinic notebooks are supposed to be entered on inmates' permanent medical charts for later reference. (T1470, 1474.) Yet plaintiffs proved that many notations regarding such serious symptoms as chest, abdominal and pelvic pain, as well as carotid pulse readings, all of which was conceded by Ms. Daly to belong in the permanent charts (T1474), are not recorded on the medical charts, and this information is unavailable for later use in diagnosis and treatment.\*

Plaintiffs' experts condemned the entire lobby clinic process, which inevitably leads to denial of adequate care. They noted that the necessary elements of a minimally adequate screening system, 1) the opportunity for confidential conversation and history-taking; 2) the space, time and equipment to perform basic physical evaluations; 3) the ready availability of an individual medical record into which the nurse screening encounter can be entered and made available to future health staff; 4) precise and narrow guidelines to limit diagnostic functions of nurses and insure proper referral of patients; and 5) prompt access to physician appointments upon referral, all are lacking at Bedford Hills. (Nolan - T479-503; Weisbuch - 577-82; Della Penna - 626-45; Rans - 909-23.)

\* See, e.g. Cutshaw - T-1475-79; Ex. 71c, 2/4, 2/6, 2/7, 2/8 and 2/14/75; Ex. 70h, 2/13/75; Ex. 14; docketed letter of 4/29/75 from Dr. Waitkevicz; Vega - Ex. 70i, 6/6, 6/9, 6/10, 6/11, 6/16 and 6/17/75; Ex. 59; Palmer - Ex. 70i, 8/5 and 8/8/75, Ex. 42; Jackson - Ex. 72a, 10/3/74; Ex. 27; T499-500.



The District Court found that various serious defects in the lobby clinic process itself and the record keeping system used at the lobby clinic lead directly to "a failure to screen, which in turn inevitably results in unnecessary suffering because of denied or substantially delayed access to a physician for diagnosis and treatment of physically distressing illnesses." (Opinion at A23.) It based this opinion on a myriad of individual cases, drawn from the 64 typical medical charts admitted into evidence, where women who reported serious and painful medical symptoms at the lobby clinic were denied or significantly delayed in gaining access to a physician. The District Court opinion describes in detail 5 of the cases where access to a physician was sought at the lobby clinic, and was not gained at all or was substantially delayed, causing unnecessary suffering. Yvonne Lee, who had informed the nurses of a history of urethral trouble, and who the nurses had difficulty catheterizing, had symptoms of urinary distress and kidney pain for a condition which ultimately required surgery; it took two and a half weeks from admission, when this problem was noted, before she was permitted to see a doctor.\* (Opinion at A19; T14-18; Ex. 67, at A 74; Ex. 33.) Paula Herbert's complaints of a nodule growing on her nose, a skin rash and shortness of breath, went unheeded for a month despite several notations by the nurse indicating urgency. (Opinion at A19; Ex. 67

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\* Defendants note (Brief at 47) that Ms. Lee's condition was difficult to diagnose. Obviously, this does not excuse their failure to promptly refer her to a doctor so that the process of diagnosis could begin.



at A 74; Ex. 71c, 1/18, 1/26 and 2/11/75; Ex. 75c, 1/28, 1/29, 1/30, 1/31, 2/2, 2/3, 2/4, 2/5, 2/6, 2/7 and 2/8/75; Ex. 25, notes of 1/16 - 2/14/75.)\* Despite many requests at lobby clinic to see the gynecologist, and even referrals from the general physician to the gynecologist, three months passed before Theresa Durante received any examination for her menstrual condition, which ultimately required surgery to control and correct. (Opinion at A19; T186-90, 283-91; Ex. 18.) Paulette Blackstock's situation was similar. She had a vaginal discharge when she was admitted to Bedford Hills and reported recent urinary tract and fallopian tube infections. She complained of symptoms of tube infection on several occasions. Finally in such severe distress that she asked to be admitted to sick wing, Ms. Blackstock saw the gynecologist after a month's delay.\*\* (Opinion at A15; Ex. 67 at A 71; Ex. 71b, 7/19, 7/24 and 7/25/75; Ex. 5.) Louise Johnson, who had suffered from toxoplasmosis of the eye (a parasitic infection)

\* Defendants' argument that Ms. Herbert's condition did not block her nasal passages and was ultimately controlled (Brief at 46-47) ignores the fact that the nurse herself considered the growing nodule an urgent matter, as indicated by the stars next to Ms. Herbert's name in her notebook; yet, no appointment was scheduled. The fact that she saw a dermatologist 3 months later for an unrelated condition is clearly irrelevant.

\*\* Defendants acknowledge this delay but seek to explain it by noting that Ms. Blackstock's condition is a chronic one. (Brief at 46.) Like other chronic sufferers, people with pelvic inflammatory disease suffer from period attacks, in this case, internal infections. Treatment with antibiotics cures the infection and alleviates acute pain. (T706-07.) This treatment was delayed for four weeks in Ms. Blackstock's case.



in the fall of 1974 at Bedford Hills and incurred permanent eye damage as a result of delayed treatment of this condition, returned to the lobby clinic with renewed complaints of eye problems on January 27, 1975. The nurse noted the complaint and wrote "Emerg." in the lobby clinic notebook. Despite this, and repeated further complaints by Ms. Johnson, two weeks passed before she saw a doctor.\* (Opinion at A19; Ex. 67 at A 72; Ex. 71c, 1/27 and 1/29/75; Ex. 29, notes of 1/27, 1/29 and 2/4/75.)

In addition to these cases, which were discussed by the Court in detail, there were numerous other examples of denial of necessary medical care because of the inadequate lobby clinic process which were proved by plaintiffs, and relied on by the District Court in support of its opinion. (Opinion at A13-14, 18.) Iris Capella did not see a gynecologist or have an internal examination for at least a month\*\* after first complaining of abdominal pains and expressing fear of complications because of an IUD contraceptive

\* There is absolutely no support in the record for defendants' assertion (Brief at 48) that the hospital personnel at the Grasslands eye clinic had been consulted regarding the nature of Ms. Johnson's complaint or made any decision regarding its seriousness. It is clear, however, that while the nurse at Bedford Hills considered her condition an emergency on Jan. 27, the only action taken by the prison was to change Ms. Johnson's already scheduled eye appointment from Feb. 13 to Feb. 10. (Ex. 29, notes and referral sheet.)

\*\* Not all of the 64 medical charts were complete through the time of trial. In Ms. Capella's case, the chart ends on March 5, 1975, a month after her initial request to see a doctor. It is impossible to state how long Ms. Capella ultimately waited for a gynecological examination.

device. (Ex. 67 at A 75; Ex. 9, notes of 2/4-3/5/75.) Candida Rivera was locked in her room after a disturbance at the prison during which she was struck on the head with a bat and rendered unconscious.. She complained to the nurse two days later of an increased swelling on her head, and again asked to see the doctor after two more days. Yet she was not seen by a phsician until a full eight days after the head injury. (Ex. 48, 9/1-9/6/74; Ex. 72a, 9/3/74; Ex. 67 at A 76.) Ruth Dobson reported pains in her left breast upon which she had previously been operated; she did not see a physician for two weeks. (Ex. 70h, 4/20/75; Ex. 17, notes of 4/20-5/3/75; Ex. 67 at A 70; T349-51.) Cleo Bacon suffered a spontaneous miscarriage and began heavy vaginal bleeding nine days later. Yet for a full four weeks, she was neither seen by a gynecologist nor given a pelvic examination. (Ex. 67 at A 69; Ex. 3, notes of 11/12-12/10/73; T345-46, 1566-76, 1962-63.) Phyllis Hapeman came to Bedford Hills on January 30, 1975, with a painful pink eye and impaired vision. Even after the nurse confirmed that she had no vision in that eye, she was not seen by a doctor for two days,\* whereafter it was determined that she had glaucoma and emergency surgery was performed. Later the same spring, she suffered a recurrence of eye pain and symptoms. In spite of her prior history and 15 to 20 lobby clinic requests, Ms. Hapeman did not see a doctor for four weeks. In November of 1975, Ms.

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\* Dr. Waitkevicz testified that in community hospital and ambulatory clinic practice, sudden blindness is considered an emergency requiring immediate referral to an ophthalmologist, including, if necessary, transfer to a hospital where an ophthalmologist is in residence. (T273.)



Hapeman was diagnosed as having a tendency to secondary glaucoma and the ophthalmologist ordered that she be returned to him upon recurrence of any symptoms. Shortly thereafter, she suffered a loss of vision and pain in her right eye of which she complained at lobby clinic. Nevertheless, she was not returned to the ophthalmologist for a full three weeks. (T145-75, 269-83, 1547-60; Ex. 67, at A 69; Ex. 66; Ex. 75c, 2/1/75; Ex. 24.)

Rosemary Cutshaw, who had a history of cardiac arrest during surgery before her admission to Bedford Hills, complained at lobby clinic on six different occasions during a two week period of chest and/or back pains, but she was not seen by a physician. (Ex. 67 at A 73; T1475-79; Ex. 71c, 2/4, 2/6, 2/7, 2/8 and 2/14/75; Ex. 70h, 2/13/75; Ex. 14; docketed letter of April 29, 1975 from Dr. Waitkevicz.) Similarly, Rosezanna Vega complained 6 times in 11 days about chest and back pains and headaches, but was not seen by a doctor until six days after the last of these lobby clinic notes. (Ex. 70i, 6/6, 6/9, 6/10, 6/11, 6/16 and 6/17/75; Ex. 59.) The lobby clinic notes regarding Ada Palmer reflect complaints of "kidney" and "pains-bottom stomach" on August 5 and 8, 1975. Again, on August 11 and 12, the nurse noted these complaints but was unable to obtain a doctor's visit for this woman. (Ex. 42; Ex. 70i, 8/5 and 8/8/75.) Paulette Blackstock, whose difficulties gaining a doctor's appointment for a tubal infection were discussed above at p. 19, went to the lobby clinic because she was suffering pain in the left eye and blurred vision.

She specifically requested a check-up by the eye mobile unit which was at Bedford Hills at the time. However, Ms. Blackstock was not seen by the mobile unit or any other eye doctor for a full five months. When she finally was examined, the optometrist referred her to an ophthalmologist for possible tissue growth on her eye disc. (Ex. 72d, 3/18/75; Ex. EE; Ex. 5, 9/4/75 Consultation.) Carol Lewin told the nurse on admission that she was suffering from an eye chalazion (cyst), but did not get to see a doctor for this and other medical problems for six weeks. (Ex. 34, Medical History, notes of 5/11/74, 7/2/74.) For other examples, see, generally, Ex. 67 at A 69- 75.

Defendants admit that even those inmates whom the clinic nurses and Ms. Geser believe need a prompt doctor appointment are forced to endure unreasonable delays before actually seeing a physician.\* Because of the limited nurse\*\* and physician staffing,

\* Both Dr. Williams and Dr. Frost were in agreement that inmates who insist on seeing a doctor should be permitted to do so. (Ex. I; T1316, 1492).

\*\* The District Court found that the nursing staff is the "crucial link in the chain of health care delivery at Bedford Hills", (Opinion at All) since in addition to running the lobby clinic, nurses prepare the physician appointment schedules, call patients to the clinic for doctors' appointments, conduct rounds of the reception, segregation, and hospital buildings, assist during all physical examinations, respond to emergency calls from the correction officers, handle routine health care inquiries, and conduct the initial interview and screening of new admissions to Bedford Hills. (T845-51, 956-76, 1419-20, 1454.) Prior to October 31, 1974, the nurses also were required to perform the work of a pharmacist by preparing individual prescriptions, although such dispensing of medication by a nurse is prohibited by New York law. (Ex. 126, pp. 12-14; Ex. 127, pp. 10-11, Ex. 95, p. 3; Education Law §6801-11; Ex. 99; Ex. 104; Ex. 105; T1426-31; Opinion at All.)

(footnote cont'd on next page)



the screening system, in Dr. Loudon's words, "breaks down due to inadequate access to physicians" (Ex. 91, p. 1). Indeed, as recently as the spring of 1975, inmates deemed by registered nurses to require a doctor's examination were forced to wait "several weeks or sometimes even a month" (Ex. 86, pp. 34-35). The situation became even graver by August 1975 as entire doctor sessions were cancelled for lack of a nurse. (Ex. 110, p. 1.) Moreover, even after the filling of nurse vacancies and a massive influx of physician staff in late 1975,\* defendants admitted at trial that

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(footnote cont'd)

Prior to the filing of this lawsuit, defendants employed only six nurses (T1423; Ex. 95; Ex. 128), although Dr. Williams considered eight nurses to be "a skeletal staff" (T1725), and Ms. Daly stated that even with eight nurses, not all essential nurse functions could be covered due to inevitable illnesses and vacations. (T1423. See also Ex. 95, p. 2; Ex. 127, p. 2.) Even after the suit commenced, and defendants raised their nurse staff to eight by borrowing two nurse items from another prison (T1341, 1423; Ex. 110, p. 1), nursing vacancies remained unfilled for months at a time. (T807, 1342-44; Ex. 128, week of Mar. 17-23, 1975 through week of Oct. 11-17, 1975; Ex. 86, pp. 6-7; Ex. 108; Ex. 110, p. 1.) It is not uncommon to have no nurse available for the night shift at least two nights a week, and other shifts often have less nurse coverage than is scheduled. (T801-03; Ex. B; Ex. 128, week of Dec. 1-7, 1975; Ex. 84, p. 140; Opinion at A12.)

\* Since the commencement of this suit, doctor hours at Bedford Hills have more than doubled, and possibly tripled. In the fall of 1973, the two staff doctors together worked a total of three to four hours a day, five days a week, although one of them was supposed to be a full-time employee of the prison. (Ex. 126, pp. 1-2; Ex. 84, pp. 62-63; Ex. 116, pp. 5-6; T833-34, 1301, 1336-37, 1433-34.) By the time of trial, Dr. Williams and his four assistants (the most recent of whom started working at the prison in Dec., 1975), together provided 8-9 hours a day of physician coverage five days a week, and three hours on Saturdays (T834-38, 1339-41, 1433, 1488), and since early 1974, Dr. Saadat has provided an additional 1-2 hours a day of gynecological care. (T832, 1300.)

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women whom nurses thought required a physician appointment are still not seen for a week to 10 days. (T1006.) As Ms. Geser explained, the problem is what to do when the nurses determine that five people "really should be seen" by a doctor that day but there is only "room for one person" in the appointment schedule. (Ex. 86, p. 38.) Moreover, even when the schedule is finally established, overriding emergencies or new admissions once again cause delays for the selected women. (Ex. 86, pp. 35, 42; T1937.) In May 1975, Dr. Frost vividly described the results of nurse shortages to his superior, Dr. Loudon: "serious problems of coverage are occurring...The facility is desperately in need of more nursing coverage...With a shortage of nurses, the flexibility is minimal with the result that the program constantly falls behind in physician services" (Ex. 108, pp. 1-2). By August 1975, Dr. Frost found the situation "devastating", and doctors were told not to appear at Bedford Hills for their scheduled clinic sessions because there was no nurse to assist them. (Ex. 110, p. 1; Ex. 111, p. 2.)

In order to remedy the unconstitutional deprivations of access to a physician for necessary medical care which are prevalent at Bedford Hills, the Court offered defendants two alternatives.

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(footnote cont'd)

Defendants' claims of a weekly optometry clinic (Brief at 8 and 33), a biweekly dermatology clinic, a neurology clinic every three to four weeks, and a podiatry clinic every month (Brief at 7-8) were not substantiated at trial. The Court found that during the nine-week period from November 3, 1975 until January 3, 1976, only one optometry clinic, and no other specialty clinics, were conducted at Bedford Hills. (Opinion at A13.)



First, defendants may dispense with screening altogether and simply provide plaintiffs access to a doctor on request within a day after the request is made (Judgment,\*¶III.A.). This would involve operating a "sick call" or "sick line" procedure which is common in prisons and the military, where a doctor would be available at a fixed time each day to see all inmates requesting medical care. However, if defendants prefer to operate a screening procedure, the Judgment requires that the medication and screening functions be separated in time and place; that screening be conducted by medical personnel with appropriate training; that it be done in accord with specific written protocols established by the doctor in charge; that all inmates have ready access to the screening process; that the screening be conducted in privacy (except where the presence of a correction officer is required for security reasons), with appropriate equipment and the inmates' medical records available, that the staff member doing the screening determine when the inmate will see a doctor (not exceeding two weeks from the inmate's request); that if the doctor's appointment is not to be conducted on the day of the screening, the inmate be provided with a written appointment slip within two days after the screening; and that defendants maintain a list of doctor's appointments including information relevant to the inmate's complaint and the date of the appointment. (Judgment, ¶¶III.B.1-9.)

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\* The portions of the Judgment regarding physician access can be found at A42-45.

## V. FOLLOW-UP CARE

In addition to the problems in gaining initial access to a physician, the record establishes that plaintiffs are repeatedly denied treatment ordered by doctors in that diagnostic tests are routinely not performed, abnormal laboratory tests are not followed-up, and follow-up doctors' appointments are not provided as ordered (Opinion at A28.)

### 1. Laboratory services

Laboratory tests are an essential aid to doctors both in diagnosing a disease and monitoring its course. (T392-93.)

At Bedford Hills, however, diagnostic tests ordered by a physician are frequently not performed. In those cases where the tests are performed, and the results reveal significant abnormalities, these results are often not reviewed by doctors at all or for lengthy periods of time, making appropriate diagnosis or treatment impossible.

Bedford Hills contains a small laboratory and the prison employs a laboratory technician, whose function is to collect samples from inmates and perform certain routine tests. Other samples are sent to a commercial laboratory or to a state laboratory in Albany where the tests are carried out. (T824-25.)\*  
The review of 64 representative medical charts revealed numerous

\* Samples for Pap tests for cervical cancer, and for tests for venereal disease are sent to a state laboratory in Albany. The results are routinely returned four or five weeks later (T1738) although defendants' own gynecologist testified that in his private practice he receives such test results within a week (T1800). Plaintiffs criticized defendants' routine use of a laboratory which causes such delays. However, the Court found that since the doctors are aware of the time which the Albany laboratory routinely takes to return test results, and continue to use this laboratory, plaintiffs were actually challenging the decision of the doctors to use a notoriously slow laboratory, rather than



instances where ordered diagnostic tests were simply not performed. (Ex.67 at A 79-80.) Five of these are detailed in the Court's opinion. Paulette Blackstock and Rebecca Booker did not receive urine culture and sensitivity tests which were meant to determine whether bladder infections which each of these women suffered had been cured.\* (Opinion at A24; Ex.67 at A 80; Ex.5; Ex.6; T1229-31.) Ms. Blackstock was also required to have a blood count by the gynecologist treating her for tubal infection and vaginitis. The order was made on August 13, 1974. On September 6, the laboratory technician noted that the order had never been written into the laboratory book, and the test was therefore not done; on September 27th the test was finally drawn. (Opinion at A24; Ex.67 at A 80; Ex.5, notes, lab report of 9/27/74.) Frances Chacon had a history of rheumatic fever, and complaints of headaches and neck and shoulder pain of one month's duration; the doctor ordered a blood count as an aid to diagnosis. As of the close of discovery three months later, there was no evidence in her medical record that this

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(Footnote continued)

challenging those responsible for carrying out doctors' orders for failure to do so. Accordingly, the Court found that plaintiffs did not prove a constitutional violation on this point. (Opinion at A25.)

\* Dr. Waitkevich testified that a follow-up urine culture is particularly important in this situation because antibiotic treatment may cause all symptoms of infection to disappear without actually eliminating the infection; the continuing infection can result in kidney damage. (T397.) Thus, defendants' assertion that Ms. Blackstock was asymptomatic (Brief at 51) misses the point.

test was ever performed, nor did defendants introduce any subsequent records.\* (Opinion at A24; Ex.67 at A79; Ex.10, notes through 9/24/75.) Thyroid tests ordered on a "stat", or immediate, basis for Patricia Narganes on December 24, 1974, were, again, not performed, until almost eight months later when a doctor reordered them. (Opinion at A24; Ex.67 at A 79;Ex. 40, notes of 12/24/74, 8/8/75, lab report of 8/12/75.)\*\*

In addition to these cases reviewed by the Court, there were numerous other incidents of defendants' failure to carry out ordered laboratory work, and/or to make the results available to the doctors seeking to use them in order to make diagnoses. Gloria Franklin had a urine culture ordered on December 10, 1974; yet 16 days later, on December 26th, the doctor treating her noted that the results were not yet available. (Ex.67 at A 80; Ex. 20, notes.) A urine sample was taken from Ernestine Davis for a culture on October 7, 1974. Ten days later, Dr. Frost reported that the results were not yet available (Ex.101, p. 2).

Similarly, blood pressure tests ordered to monitor the progress of inmates suffering from hypertension are admittedly not performed as ordered, (T1543) despite the fact that defendants consider the treatment of hypertensives to be one of their main priorities.

\* Defendants claim that Ms. Chacon sometimes intentionally did not appear for laboratory appointments. However, no written appointment slips are utilized and their system for notifying women of such appointments is admittedly ineffective. (See discussion, infra at 32-34). Furthermore, there is no evidence from Ms. Chacon's medical record that defendants ever attempted to notify her to report for this blood count. (Ex.10, notes, 6/21 to 9/24/75.)

\*\* The fact that Ms. Narganes' test result was ultimately negative does not, as defendants suggest (Brief at 52) mean that the eight month delay was defensible. Obviously, until a result is obtained, a doctor cannot diagnose the patient's condition. Defendants frequently use this approach to justify substantial delays in diagnosis and treatment. See, e.g., Angie Vasquez, p. 35, Minnie Wrenn, p. 39.



(Ex.87, p. 107.) For example, Dr. Williams ordered that Luz Pizarro's blood pressure be taken twice a week for 8 weeks, and specifically directed that the results be entered on her medical chart. Yet Ms. Pizarro's blood pressure was recorded only twice during that two month period. (Ex.44, notes of 2/21, 2/25, 3/17 and 3/19/75.) Other hypertensive patients were similarly denied this ordered care. See charts of Lucy Jackson (despite hypertensive changes of her heart, and doctor's order to have blood pressure read at least once a week, no blood pressure was taken for three months), (Ex.27, notes of 4/24 and 7/28/75); Francis Chacon (blood pressures ordered twice a week for thirty days, but done only twice), (Ex. 10, notes of 5/19, 5/27 and 6/13/75); Patricia Narganes (blood pressures ordered twice a week for two weeks, not recorded at all during that period, and recorded only twice in the following seven months), (Ex. 40, notes of 1/30, 2/19 and 8/6/75.)\*

Another recurring problem is that the results of Pap tests, taken to determine the presence of cancer of the cervix, were often unreadable because of an obscuring inflammation, but were not repeated. Although defendants claimed that their policy in this situation is to treat the inflammation and repeat the

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\* In addition to not receiving ordered blood pressure tests, the Court found that hypertensive women routinely did not receive medications prescribed for their condition, because the system for renewing medications for the chronically ill was not functioning properly. (Opinion at 30; see, e.g. Ex.27, medication order sheet, notes.) However, with regard to plaintiffs' claims that there was no functioning system for the management of those with chronic disease, the Court found this a challenge to "matters of medical judgment" which did not raise a constitutional question. (Opinion at A30.)

Pap test (T1008, 1783-84), this is often simply not done. For example, Josephine Russell's admission Pap smear was impossible to test for cervical cancer due to "severe obscuring inflammation". There is no evidence that this result was ever brought to a doctor's attention, and no new Pap test was ever ordered or performed. (Ex. 67 at A 82; Ex. 51, lab report of 11/12/74.) Similarly, Santa Diaz had an admission Pap smear which could not be read due to severe inflammation. It went completely unnoticed for 17 months, before the inflammation was treated and a new Pap smear taken. (Ex. 67 at A 81; Ex. 15, lab report of 10/30/73, note of 3/21/75.) Cora Romain had a Pap smear taken on admission which likewise could not be read for cancer because of severe inflammation. It was not noticed, and therefore not repeated for over three months, when she finally received an admission general physical examination. The repeat test also showed severe inflammation, again preventing performance of the cancer test. This result, too, went unnoticed, until Ms. Romain finally received an admission gynecological examination some eight months after her admission to Bedford Hills, and a third smear, on which the cancer test could be performed, was finally taken. (Ex. 67 at A 82; Ex. 50, notes, lab reports of 12/26/73, 3/6/74 and 9/3/74.) Other woman presenting this situation were similarly ignored. See charts of Carmen Lozada (Ex. 67 at A 81; \* Ex. 35, notes, lab report); Ada Palmer (Ex. 67

\* There is a typographical error in Ex. 67 regarding the date of Ms. Lozada's treatment.



at A 82; Ex. 42, note and lab report of 9/13/74, note of 11/19/74); Theresa Durante (Ex. 67 at A 82; Ex. 18, notes and lab reports.) In addition to not receiving the Pap test for cancer, these women were also denied treatment for the cervical inflammation which the test revealed.\*

The threat of cervical cancer is not merely theoretical. Four cases of cervical cancer were discovered among Bedford Hills inmates in less than one year. (Ex. 107.) With this history of positive cancer cases identified through Pap testing, defendants' repeated failure to promptly treat inflammation and obtain cervical smears which can be subjected to the Pap test is particularly shocking.

Defendants did not deny that these laboratory tests were not performed (nor could they, since the information was gleaned from their own records), but, in their defense, claimed that plaintiffs fail to come to scheduled appointments. However, they completely failed to substantiate this claim, and it was ultimately rejected by the District Court. (Opinion at A28.) Indeed, defendants admitted that they were aware of serious defects in

\* Dr. Waitkevicz testified that inflammation on a Pap test may indicate serious infection of the cervix, and that chronic inflammation of the cervix may make a woman more prone to develop cancer later in life. (T408.) It is therefore common gynecological practice to treat inflammation whether or not the patient complains of symptoms. (T703.) Dr. Saadat, who is a gynecological specialist, did not dispute this point. Nevertheless, the medical records show that women whose Pap tests reveal inflammation are routinely not treated promptly or at all for this condition.

their system for notifying plaintiffs of laboratory appointments. Over a year before trial, Dr. Williams directed the laboratory technician to abandon her system of notifying inmates of scheduled tests, which was to submit a written list to the correction officers in the housing buildings, and to telephone the housing areas instead, keeping a record of the name of the officer to whom she spoke. (T1504-05, 1518.) However, she continued to use the written list system, although she knew it did not work. (T1848-49, 1857.)\* The laboratory technician could remember only one specific incident where a woman had actually refused to come to the laboratory. (T1854.\*\*) And the solution she presented to the women, to come to the laboratory whether or not they receive notification from their correction officer, though well meaning, ignores the harsh reality of prison life; as noted above at p. 8, a woman who moves about the institution without authorization from a correction officer will

\* The haphazardness of the technician's efforts to inform patients of scheduled laboratory appointments is illustrated in her own testimony:

If I don't know that they are downright refusing, I usually will try to reschedule them a couple of times and try to, if I happen to see them somewhere, ask or mention to them, did they know about it? And, if so, why didn't they come?

If they didn't know about it I tell them maybe tomorrow I will reschedule them again so that they should try to come down whether the officer notifies them or not. (T1858.)

\*\* Dr. Williams, who made a similar claim that women refuse to come to scheduled doctors' appointments (see, infra. at 40), could not remember a single specific incident of refusal. (T1508-09.)



incur disciplinary charges. The Court found that defendants had not proven that "failures to perform ordered diagnostic work resulted from any lack of cooperation on the part of the women." (Opinion at A24.)

Another repeated problem with regard to diagnostic testing is that laboratory test results are not promptly reviewed by doctors, resulting in systemic denial of diagnosis and treatment to women suffering from various illnesses. Defendants' avowed practice is to have normal test results filed by a clerk without review by a doctor; abnormal results are put aside to be reviewed by the doctor who ordered the test. However, the doctors do not promptly examine all abnormal tests results, but only those which are most seriously abnormal, a judgment left to the lab technician.\* Dr. Williams testified that he reviews only the most serious abnormalities on a daily basis; he merely "glances" at the other abnormal results "as time permits". (T1679-80.) Similarly, Dr. Saadat testified that "really extremely abnormal" results are brought to his attention immediately, and that less extreme abnormalities are brought to his attention the next time the patient comes to see him. (T1769-70.)\*\*

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\* The lab technician admittedly is not trained for this function; for example, she did not know that a cytology test is a test for cancer. (T1861-62.) And since the doctors do not routinely initial laboratory test results, it is impossible to determine whether all abnormal results have actually been reviewed by a doctor. (T1683.)

\*\* Dr. Saadat's practice does not take into account the fact that due to defendants' recordkeeping failures, plaintiffs regularly encounter delays, sometimes of months' duration, in the scheduling of follow-up appointments. (See, infra, at 37-41.)

As a result of this haphazard system of laboratory review, significant abnormal test results are overlooked altogether or for significant periods of time while patients are in distress and suffering from undiagnosed and untreated medical conditions. Three such examples were discussed by the Court. Angie Vasquez had an extremely abnormal result on a liver function test (SGOT) performed on September 13, 1974, which occasioned a telephone report from the outside laboratory. The result was noted on her medical chart the next day, and although a doctor at that time ordered a medical examination "as soon as possible", her medical chart shows no evidence that further action was taken, and no note of a doctor's examination by Dr. Tschorn (Appellant's Brief at 52) or by any other doctor, appears. On October 16th, Ms. Vasquez informed a nurse that she had a history of liver disease, and complained of bruising on her arm which she stated was related to this condition. This, too, was noted on her chart, but again no action was taken. Finally almost two months after the abnormal test result was received, a nurse noted additional bruises on her extremities, and Ms. Vasquez was admitted to sick wing, although she was not examined by a doctor for three more days.\* (Opinion at A26; Ex. 67 at A 82; Ex. 58, notes, lab report of 9/12/74.) Mary Reed was suspected of having a peptic

\* Dr. Waitkevicz testified that Ms. Vasquez's liver function test was ten times higher than the normal value. (T1973.) Although Dr. Williams stated without explanation that there was no connection between the test result and the bruising (T1652-53), Dr. Waitkevicz explained that the test was a sign of liver inflammation, and that since the liver manufactures the proteins which allow the blood to clot, severe liver disease can cause a decreased amount of clotting factors and lead to easy or unexplained bruising (T 1973-74, 1986.)



ulcer, and submitted stool samples to be tested for internal bleeding. Positive results were returned from the laboratory. Yet Ms. Reed was not seen again by a doctor for over a month, despite two notes by Dr. Williams ordering that she be scheduled for an examination.\* (Opinion at A26; T398-99; Ex. 67 at A 81; Ex. 47, notes of 12/20, 12/21/74, 1/5 and 1/27/75.) Geraldine Strong had a blood test showing anemia; this condition was not noted by a doctor nor a treatment plan begun for a full two months afterwards. (Opinion at A26; Ex. 67 at A 82; Ex. 54, lab report of 7/9/75; note of 9/5/75.)\*\*

In addition to the cases described by the Court, plaintiffs presented evidence of other similar incidents which the Court relied on to support its conclusion that defendants regularly failed to follow up significant laboratory results. (Opinion at A13-14.) In Bernadette Brown's case, a urinalysis report showed pus; but a urine culture, the test for infection, was not even ordered for two weeks. The results obtained 4 days later showed infection; yet Ms. Brown did not receive any treatment for yet another 2 weeks. (Ex. 67 at A 81; Ex. 8, notes and lab reports.) Helen Lavore had two positive F.T.A. serology tests,

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\* The fact that Dr. Williams wrote two separate notes, a month apart, ordering that this woman be examined for internal bleeding, clearly suggests that he considered the matter to be other than routine.

\*\* Defendants' assertion (Brief at 53) that civilians suffer from the same condition as Ms. Strong obviously does not excuse this lack of treatment.

a specific test for syphilis (T1399.) On admission, she denied having venereal disease or ever receiving treatment for it. Although defendants claim a policy of retesting after one week inmates with positive syphilis tests who deny a previous history of the disease,\* Ms. Lavore's serologies were performed several months apart, the second test was not followed up, and there is no evidence that she was ever treated for syphilis (T406-07, 1392; Ex. 67 at A 81; Ex. 31, notes, admission medical history, lab reports of 12/13/73 and 3/28/74; Ex. F.). Similarly, Judy Wheat had a positive F.T.A. test for syphilis; although she, too, denied a prior history of the disease, she was not treated, not retested for four months, and when retested, an F.T.A. test was not done. (Ex. 67 at A 81; Ex. 62, admission medical history, lab reports of 4/13 and 8/12/74; T407, 1335.) For other examples, see Ex. 67 at A 81-82.)

## 2. Doctors' Appointments.

The District Court sustained plaintiffs' claims that follow-up appointments ordered by doctors to be conducted on a specific date or within a specific time period are routinely not scheduled within the time specified or within a reasonable time thereafter. Like the follow-up laboratory problems discussed above, the failure to scheduled follow-up appointments which are ordered by a doctor because of their necessity to the health of the patient

\* Since persons who have once been infected with syphilis have positive syphilis tests all their lives, whether or not they have been successfully treated for this disease, a patient's history of prior treatment is important in determining whether treatment is currently required. Where, as here, a patient denies prior treatment, a positive F.T.A. test result indicates that she may have an active case of syphilis and should be treated for it. (T1390.)



was found to unconstitutionally deny plaintiffs adequate medical care.\*

Plaintiffs presented numerous individual incidents of failure to provide scheduled medical appointments. In addition, they presented statistical evidence, drawn from defendants' own appointment books, which proved that failures in this regard are not occasional happenstances, but regular occurrences. Between October, 1974 and July, 1975, an average of 22.2 follow-up appointments were ordered by doctors each month. Of these, an average of 9.3 were not conducted on the ordered date or within five days thereafter. (Ex. 68, pp. 5-6, and Ex. F.)

This systematic failure to provide follow-up doctors' appointments causes real and substantial harm to plaintiffs, who are unable to make any independent arrangements to see the doctor, and must await scheduling by defendants. (See, generally, physician access, supra at 11-26 .) Two cases cited by the District Court were those of women with demonstrable gynecological pathologies which were causing them distress. Carmen Garcia was referred to the gynecologist by the general practitioner for a vaginal infection. She was not seen for three months, until March 18th. At that time, medication was prescribed and the

\* Plaintiffs also challenged their placement in medically inappropriate work assignments, and delays in scheduling outside appointments with specialists and outside consultations regarding elective surgery. The Court found that the delays and denials encountered here were attributable to medical judgments, in that the doctors never specified a time by which these appointments should be scheduled, and that a federal court was therefore not the proper forum for these claims. (Opinion at A30-36.)

doctor entered an order that she be returned to see him in two weeks. However, her return appointment was not rescheduled for another two months, while her condition persisted. In August she was treated for a recurrence of the same condition. The doctor ordered a return visit in three weeks. However, four and a half months passed before she was seen by him again. Her problem thus spanned an entire year.\* (Ex. 67 at A 71; Ex. 21, notes, letter of 7/25/74; opinion at A27.) Minnie Wrenn's history is even more dramatic. She was seen by the gynecologist on September 12, 1974 for abdominal pain. He diagnosed a small myomatous (i.e. tumorous) uterus, and ordered her returned in two weeks. However, an appointment was not provided for her for a full eleven months. Her condition had persisted, and he ordered that she return again. This time the reappointment was conducted as ordered, and a surgical consultation was ordered to determine whether a hysterectomy was called for. (Ex. 67 at A 75; Ex. 64, notes of 9/12/74 and 8/18/75; Opinion at A27.) Many other such incidents appear in the medical records and were considered by the District Court. See, e.g., Ada Palmer, two month delay (Ex. 67 at 74; Ex. 42, notes); Angie Vasquez, five week delay (Ex. 67 at 75; Ex. 58, notes of 9/30 and 11/27/74);

\* Defendants' description of the facts in this case (Brief at 53) is extremely misleading. They note that following Ms. Garcia's March 18th appointment, "her name was placed in the appointment book for Dr. Saadat for May 1st." This ignores Dr. Saadat's order on March 18th that the patient be returned to him in two weeks. (Ex. 21, note of 3/18/74.) In August, again, Dr. Saadat ordered her to be returned in three weeks, and a four and a half month delay ensued. Her visit to Dr. Tschorn, who is not a gynecologist, on August 28th was for unrelated back and leg pain. (Ex. 21, notes of 8/2 and 8/28/74.)



Yvonne Lee, eleven week delay (Ex. 67 at 74; Ex. 33, notes); Elizabeth Holcomb, one week delay in scheduling gynecological appointment, at which time patient had her menstrual period, resulting in further two week delay (Ex. 67 at 74; Ex. 26, notes of 4/20, 5/8 and 5/23/75); Paulette Blackstock, two month delay (Ex. 67 at 71; Ex. 5, notes of 8/14 and 12/5/74); Gloria Franklin, two week delay for urinary tract infection (Ex. 67 at 74; Ex. 20, notes of 9/27 and 11/2/74.)

As with the case of laboratory tests not performed, defendants again asserted that patients fail to come to scheduled appointments of their own volition, and the Court again rejected that argument. The Court found that defendants' system the scheduling of follow-up appointments\* is a "hit-or-miss proposition", and that defendants' methods for informing inmates that they are due to see the doctor simply do not work. (Opinion at A28.)

Further, the Court found that on at least several occasions, medical appointments which had been ordered by doctors were consciously disregarded because of correctional considerations.

\* For regular doctors' appointments, the medical clerk calls the lobby officers in the various housing buildings, and informs them of the women from their building who are scheduled for medical appointments. However, the women have already left their housing buildings by the time the call is made, so the lobby officer must call the work or school assignment of each woman who is scheduled for an appointment, and deliver the message. (T1020, 1023-24.) Six or eight women are called to the medical building together, and if one is called away for other obligations, a new doctors' appointment is generally not made for her. (T1940.)

Calls for appointments with Dr. Saadat, the gynecologist, are made to the housing areas before 8:00 A.M., when women generally have not begun their daily assignments. The corridor officer is supposed to inform each woman of her appointment. (T1016.) However, a woman who is attending lobby clinic at that time may not return to her housing unit before going to her assignment, and

(Footnote continued)

Thus, when Ms. Blackstock was scheduled to see Dr. Saadat by his order, a nurse noted that the inmate was "seg locked on corridor", and cancelled her appointment (Ex. 5, note of 9/6/74).\*

Similarly, Carol Lewin's appointment with an optometrist was cancelled because she was in segregation, and not rescheduled for three months. (Ex. 34, eye record; Opinion at A27-28).

See also Nora Arner, order for catheterized urine disregarded because inmate in segregation, Ex. 67 at A 20; Ex. 1, note of 2/13/75; Ms. S \_\_\_\_\_ L \_\_\_\_\_, Ex. 75b, 9/4/74, #13; Ms. B \_\_\_\_\_ T \_\_\_\_\_, Ex. 75c, 9/13/74, #26.\*\* See others at Ex. 67, A88.

3. Remedy for follow-up violations.

In order to remedy the repeated failure of defendants to inform patients of scheduled laboratory tests and follow-up doctors' appointments, the Judgment provides for written notice to the inmate of the date and time of her appointment unless it is to be held on the day ordered. The laboratory technician and

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(Footnote continued)

thus will not get the message about her appointment.(T1913-16.)

\* Defendants challenge the Court's finding that when Ms. Blackstock was released from segregation and her appointment with Dr. Saadat rescheduled, she did not receive notice of the new appointment. (Opinion at A27.) They claim (Brief at 54) that the new appointment was scheduled for September 26th. However, Ms. Blackstock's medical record clearly states "9/27/74 Called for Dr. Saadat did not come". (Ex. 5, notes.) This supports the Court's conclusion that Ms. Blackstock never received the message, since Ms. Blackstock was present in the medical building on September 27th receiving laboratory tests (Ex. 5, lab report of 9/27/74), and presumably would have attended the doctor's appointment down the hall had she known it was scheduled.

\*\* Initials are used to refer to women who have not executed medical releases but whose names are mentioned in the medical logs in evidence. (T1087-89.)



correction staff are also to be notified. (§ IV. A and § IV. E.)\*  
In order to insure that laboratory test results are followed up,  
the Judgment provides that all tests shall be reviewed by some  
member of the medical staff when received by the facility. All  
tests significantly outside the normal range shall be  
immediately communicated to the doctor on duty or on call. All  
other test results shall be shown to the doctor who ordered the  
test on the first day he or she is available at the facility;  
and the doctor shall initial them upon review. Within ten days  
of receipt of test results, inmates shall receive either  
written notice of normal test results or an explanation from  
the doctor of abnormal test results, and of any appropriate  
follow-up. (§ IV.B, C and D.) Appropriate laboratory records  
shall be maintained. (IV. F.)

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\* The portions of the Judgment regarding follow-up can be  
found at A45-47.

## VI. SICK WING

"Sick wing" is located in the hospital\* building at Bedford Hills and houses those patients who suffer from high fever, high blood pressure or abnormal pulse, breathing or gait, have just undergone a convulsive seizure, have just returned from hospitalization for surgery or emergency treatment, or who for any other reason require "closer observation" and "more nursing services" (Ex. Q; Ex. 69; Ex. 120; T707-08, 963, 1099-1100, 1297, 1546, 1956; Ex. 86, pp. 57-58; Ex. 87, pp. 157-60, 163). The trial record establishes and the Court found that the physical structure of sick wing as well as the staffing and procedures employed by defendants necessarily deny these sick patients the close observation and access to medical personnel for which defendants place them there. (Opinion, A17-18.)

At the time of trial, sick wing consisted of approximately 19 rooms on two floors of the hospital building. (T60-61, 778, 783, 1122, 131; Ex. 84, p. 150; Ex. 86, p. 56; Ex. 126, p. 2; Ex. A.) Four of these rooms, each of which contained a toilet, were usually used to house mental observation cases\*\* who were kept locked in these rooms, but were on occasion used for sick wing patients in disciplinary status or who needed closer access to a toilet. (T182, 863, 1129-30, 1832, 1957; Ex. 86, pp. 53, 56-57; Ex. 96, p. 2.) The

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\* The hospital is actually not certified as a general hospital, nor is it used as such by defendants.

\*\* Psychiatric care is not an issue in this lawsuit.



remaining rooms, used to house ordinary sick wing patients, did not contain toilets and were never locked.\* (T1129, 1133-34.) The sick wing rooms are located along a corridor, and the door at the end of the corridor is always locked. No personnel are stationed on the sick wing corridor. (T61, 1830). A correction officer's station is located about 20 feet across a lobby outside the locked corridor door (Exs.78 w, x and y, T61,775, 779-81, 1830), and the nurse on duty is stationed in the ambulatory care clinic, a separate wing of the first floor separated from sick wing by two locked doors and the lobby (T774-75, Exs.78 w and y). Until a few months before trial, the door at the end of the sick wing corridor was a thick solid wooden door with a small grated window. (T181,783, 1831.) A heavy mesh steel door, which makes it easier to hear and see the inmate corridor has now been installed, but the solid wooden door remains and is closed at the discretion of the correction officer on duty. (T782, 1827-29.)\*\*

\* Several changes in sick wing have occurred since trial. Only 8 rooms, all on the first floor, are currently used for sick wing and mental observation. All of these rooms now have toilets installed in them, and inmates residing in them are now locked in their rooms during the nighttime hours. (Memorandum in Support of Plaintiffs' proposed Judgment at 5.)

\*\* Although defendants argue that the solid wooden door is only closed "in very unusual circumstances" (Brief at 45), their own witness, Correction Officer Rivenburgh, testified that the solid door is generally closed during the daytime hours. (T1827-29.) The court found that the wooden door closes off the sick wing corridor "at least on some occasions." (Opinion at A16.)



Sick wing rounds are conducted by nurses twice or sometimes 3 times daily,\* in order to administer medications. Correction officers are supposed to conduct rounds of the sick wing corridor every half hour, but plaintiffs who had been confined on sick wing testified that correction officers actually only enter the corridor to give out meals or at the change of shift, testimony which was not refuted by defendants.\*\*

Despite the patients' physical separation from correction and medical personnel, and the infrequency of sick wing rounds, there are no call buttons or other mechanical system for summoning assistance.\*\*\* (T512, 1831-32; Ex.127, pp. 6-7.) The only means a

\* Defendants assert that nurses make four rounds of sick wing each day. (Brief at 29.) However, this was not proven at trial. Ms. Daly testified that nurses regularly make three rounds, in the early morning, at noon, and in the evening, and make a mid-afternoon round as well if there are medications to give out. (T814-15, 817-18.) But Ms. Daly admitted that she was not personally present at these functions, and the Court ruled that her testimony was only probative concerning instructions given to the nursing staff. (T813, 820, 822.) Ms. Geser, the nurse in charge of the clinic functions, testified that nurses make only two regular rounds in sick wing (Ex.86, pp. 50-52), and Ms. Hapeman testified to the same effect. (T180.) The Court found that nurses make rounds "at least twice a day." (Opinion at A16.)

\*\* While Sergeant Rivenburgh testified that she personally conducted rounds every 15 minutes when she was on night duty as an officer at some unspecified time before September 1973 (T1824), defendants presented no witness with direct knowledge of officer rounds during the period in litigation (see T1132), as plaintiffs did in presenting Yvonne Lee, who had been in sick wing some 25 days on four separate occasions between June and October 1975 (T1955). Indeed defendants did not even produce the logbook in which officer sick wing rounds are supposed to be recorded (T1826). Moreover, Ms. Daly, in speaking of her ten years on night duty would only venture that "I know on night duty they are supposed to make rounds every half hour" (T1135) (emphasis added). See also Ex.96, p. 2.

\*\*\* The need for a call mechanism, which was found to exist in the conditions described at trial (Opinion at A17), is of course exacerbated by the new practice of locking all sick wing patients in their rooms at night. See footnote at p. 44, supra.



patient has of attracting attention is to shout or bang on the door at the end of the corridor, (T61-62, 76, 180-81) or, if her room is locked, as is now the case at night, to shout and bang on the locked door of her own room.

The trial record contains descriptions of many dangerous and terrifying incidents, which the Court found proved, "by the overwhelming weight of the evidence that there is a serious lack of communication and medical observation in sick wing." (Opinion at A17.) In one instance, Rosezanna Vega was locked in a sick wing room immediately upon her return from a hospital emergency room, where she had received forty-four stitches in her face, eye and arm for lacerations received in a fight. A nurse's note written an hour and fifteen minutes after Ms. Vega was placed in the locked observation room states: "Officer advised me that girl fell in her room. Found lying on floor next to toilet. Girl said she fell off toilet and hurt her head." Despite this incident, Ms. Vega was placed back in her bed, locked and unattended. (Opinion at A17; Ex.59, notes of 1/19/75; Ex.67 at A88.)\* A second incident recounted by the Court involved a woman who was suffering from either hysteria or a seizure, who was observed by plaintiffs' expert witnesses on their tour of the facilities. The woman was obviously

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\* Defendants' argument that if Ms. Vega had not been a prisoner, she would have returned home and suffered the same consequences (Brief at 44) is unsupported by the record. There is no evidence that the hospital would have released Ms. Vega after she received 44 stitches in her face, eye and arm if they did not know that she would be placed in the prison infirmary with adequate coverage by nurses and correction officers.

in distress, but was left observed only by other patients while the nurse left the floor to obtain necessary medication for this woman. (Opinion at A17, T509-10; 652.)

As the Court noted (Opinion at A13-14, 17), many similar instances were presented and unrefuted at trial. Yvonne Lee testified that she awoke one night in August 1975 on Hospital 2 with severe pains both in her mouth, as a result of dental work she had received that day, and in her kidney and pelvic areas. Although her repeated knocking on the corridor door was sufficiently loud to awaken other inmates on the corridor, it produced no response from the officer. The inmates improvised a make-shift hot towel compress for her face and then continued to bang on the door for the officer in order to get her medical assistance. A full hour later the officer arrived but yet another half-hour elapsed before the nurse responded and provided treatment for Ms. Lee's dental condition and medication for the pains (T75-78; Ex.33, note of 8/27/75).

On another night, Ms. Lee, hearing unusual noises in the adjoining room, went next door and found an inmate having difficulty breathing and turning red in her face. Ms. Lee ran first to get help from a neighboring inmate and then to notify the officer. Although the inmate suddenly appeared to stop breathing, the nurse had not yet arrived and thus only the inmates were available to attempt to revive her by rubbing her hands and chest. When the nurse finally arrived a half-hour later, she brought with her



only a stethoscope. After a quick check with the stethoscope, the nurse left once again leaving the inmate, still apparently unconscious and not breathing normally, with only the inmates and an officer in attendance. Ultimately the nurse returned with a doctor and the inmates were made to leave the room.

(T79-84.)

There are also serious delays in providing medical attention to inmates having convulsive seizures. On one night, a sick wing patient, who had just returned from surgery at an outside hospital, heard a coughing noise in her neighbor's room and, upon entering, found her on the floor, foaming at the mouth. The inmate struggled to force a tongue depressor into the convulsing patient's mouth and to hold her so she would not choke on her saliva or hit her head during her convulsions. The assisting inmate's calls for help finally produced an officer after 15 minutes but a nurse did not arrive until at least another 15 minutes had elapsed. As a result of her struggles to protect the convulsive patient, the other inmate was herself injured and required treatment (T107-110, 112-113; Ex. 74m, 9/18-19, 1975). For another similar incident, see T113-16.

Inmate Phyllis Hapeman testified that when she was locked in an observation room, she observed an epileptic who was confined in another such room for disciplinary reasons thrashing on the floor, foaming at the mouth and repeatedly striking her head against the concrete floor. Through the efforts of another inmate who was in an unlocked room, a correction officer finally

appeared after fifteen minutes, only to look in, re-lock the door and leave. Another half-hour passed before the officer and a sergeant returned with a nurse who, after the door was unlocked, was finally able to administer medication for the seizure (T182-84; Ex.52, notes of 4/23 and 4/30/75; Ex. 74k, 4/30/75.)

The complete isolation and lack of regular nurse observation and care in sick wing is not alleviated by regular access to a physician. Until just a few months before trial, no doctor made rounds in sick wings (T1120; Ex. Q.) Rather, those patients fortunate enough to be selected to see the doctor were called down to the clinic for examination. (T1120.) Yet, the evidence established that such examinations were infrequent, and that the records kept of these encounters were even less complete than lobby clinic records.\* For example, Rebecca Booker, a patient with a history of pelvic infection was admitted to sick wing for severe abdominal pains but was not seen by a physician for 15 days. (T364; Ex.6, notes of 5/24 - 6/8/73; Ex.67, p. 5.) Yvonne Lee, admitted to sick wing because of pain over both kidneys and suspected kidney stones, was not seen for a week and then only after a threat to sue (T62-65; Ex.33, 6/17 - 6/24/75.) Mary Kerr, a newly admitted diabetic complaining of headaches, dizziness and weakness, was not examined by a physician for a week after placement in sick wing and then only after refusing to take life-

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\* The problems of physician access in sick wing parallel those encountered by women in general population seeking access through the lobby clinic. See, generally, pp. 11-26 supra.



sustaining insulin until seen by a doctor. (Ex. 30, 7/16 - 7/23/74.) Physician rounds of sick wing were infrequent. (See Ex.68; Ex. E - only 3 sick wing patients seen in all of August, 1974; only 2 seen in March, 1975; and only 14 seen in May, 1975 on 4 separate days.\*) Both Dr. Williams and Ms. Daly testified that daily physician rounds, previously "impossible" given the limited staffing (Ex.86, p. 51) still often do not occur (T1122, 1540), and as a result defendants will often only call down for physician examinations the 1 or 2 "exceptionally ill" patients in sick wing. (T1123.) The Court found that sick wing rounds are often not conducted. (T at 17.)

Both Dr. Weisbuch and Dr. Della Penna, who administer health programs serving thousands of inmates, rejected defendants' sick wing arrangements precisely because they did not provide the continuous medical observation which was clearly intended by a doctor's decision to place such a patient in sick wing. Dr. Della Penna stated that "the only reason [for admission to sick wing] would be to observe them" and in the Bedford arrangement "there is no chance for observation." (T652.) Dr. Weisbuch agreed that "you are not providing the kind of medical coverage or the medical overview that is essential and presumably required when you place

\* In January 1974, the average sick wing population was 10. (Laboratory Report, p. 1, Department of Health, Appendix 3 to Supplemental Answer to First Set of Interrogatories.) However, Ms. Daly testified that in the fall of 1975, strict new rules on admission had to be implemented because sick wing, which then consisted of 18 or 19 rooms, was too full (T1121-22). Now that the sick wing has been reduced to only 8 rooms it is fair to assume that the women confined there at any time are the few sickest in the institution.

that person in the room in the beginning." (T583.)\* Their opinion echoed that advanced by the Joint Commission on Accreditation of Hospitals, which surveyed the Bedford Hills infirmary in October, 1973 at defendants' request and recommended that call mechanisms be installed in the rooms and toilet areas. (Opinion at A17; Ex.133; Ex. 127, pp. 6-7.) Defendants own memoranda, introduced into evidence, reveal their full awareness of their inability to provide adequate medical observation in sick wing. (Opinion at A17. See e.g., Ex.91, p. 2; Ex.31, Letter of Dr. Tschorn of June 10, 1974.)

The Judgment of the District Court is written to remedy the specific inadequacies in sick wing found by the Court to violate plaintiffs' constitutional rights. Thus, the Judgment requires that an inmate not be placed in locked rooms in sick wing unless she is there for psychiatric reasons or has been transferred from punitive segregation. Provisions for regular observation of patients in locked rooms are included. (Judgment, ¶II. A.)\*\*The Judgment directs the removal of the solid wooden door at the end of the sick wing corridor, leaving the locked steel mesh door which meets security needs yet affords visual observation of the entire corridor. (¶II. B.) Emergency equipment must be kept in or near sick wing, and the medical staff authorized to call directly

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\* Both doctors described the prisons where they provide health care as having, at minimum, an open, multi-bed infirmary area immediately adjacent to the nurse's station which is directly overlooked by the nurse on duty 24 hours a day. (T584-85, 652-53, 653.)

\*\* The portions of the Judgment regarding sick wing can be found at A41-42.



for emergency transportation to a hospital when necessary. The staffing of a nurses station in or near sick wing from 4 P.M. to 8 A.M., with nurse rounds at least once every two hours during that time (§II. C.); the installation of a mechanical buzzer or bell system which can be operated from the inmates' bed and which terminates at the nurses' station (§II. D.); and daily doctor rounds Monday through Saturday (§II. E.), are designed to afford adequate medical observation and communication and care. Finally, records of sick wing rounds by all personnel are to be maintained. (§II. E and F.)

VII. FAILURE TO INSURE DELIVERY OF MEDICAL CARE

The Court found that many of the systemic problems which lead to the denial of medical care at Bedford Hills are attributable to defendants' inadequate records and to the absence of an ongoing system of supervision and review. Experts testified that such review is a minimal requirement of adequate medical care (T610) because it insures that vital medical functions are performed and services delivered. (T458, 467, 561, 564.)

The lobby clinic books in which nurses note inmates' medical complaints are not maintained as an official medical record and nearly all the information they contain is lost for review. (Supra, pp. 16-17.) The screening process, and the way in which priorities are set and access to a doctor determined, goes wholly unreviewed. Ms. Daly, the nurse-administrator, has only visited the lobby clinic once in the past year (T1448) and did not check to see that important lobby clinic notations are recorded on inmates' charts. (T1474.) Neither Dr. Frost nor Dr. Williams, who

are responsible for the delivery of medical care, has ever seen the clinic in operation, nor examined the notebooks. Dr. Williams was never even in the room. (Supra, p.15.) Nor did Dr. Williams have any awareness of the system for scheduling doctors' appointments. (T1705.)

In the laboratory, no record is kept of whether laboratory tests are actually performed\*. It was only fortuitous that the fact that a large number of syphilis tests were not done was discovered, months after the samples were sent to the Albany laboratories. (T1235-36; Ex.67, p. 12.) Moreover, there is no simple way to determine if laboratory tests are performed within a reasonable time, or, once done, if they are reviewed by doctors. (T1683.)

Similarly, no effective methods for informing patients of scheduled appointments with doctors or with the laboratory technician have been devised. (Supra, pp. 32-34, 40.)

Indeed, the persons responsible for the delivery of medical care to plaintiffs do not perform any systematic review of any part of the system. Ms. Daly who is responsible for supervising the staff nurses, takes no part in the lobby clinic, does not check to see that clinic notes are recorded, and does not participate in determining priorities for doctors' appointments. (T1448, 1470-79, 1865-66; Ex.84, pp. 53, 152-53.) Dr. Williams, the

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\* Laboratory Report, N.Y. Dept. of Health, Appendix 3 to Supplemental Answer to First Set of Interrogatories, T732.



facility health services director, is unfamiliar with virtually all the basic administrative procedures, and disavowed any intention to get involved in "the book-keeping system". (T1666-67.) He is thus unaware of lobby clinic procedures, problems of doctor access, the scheduling of appointments, and the laboratory technician's records. (T1663-65, 1669-70, 1684-85, 1689, 1691, 1705, 1711.) Dr. Frost, the primary supervisor of medical services at Bedford Hills (T1289-90), is equally unfamiliar with major procedures (supra, p. 15). He has never, for example, investigated the length of time it takes to see a doctor following a request at lobby clinic although he receives many complaints about physician access. (T1365-68.)

Since defendants' failure to insure delivery of medical care by instituting sound record keeping methods and supervision permeate the entire record of this case, the Court required defendants to keep certain records and to audit their system, to insure that ordered care is in fact delivered to plaintiffs. Specifically, the Court ordered that records be kept of sick wing rounds (Judgment, ¶II. F), doctors' appointments (¶III B(9)), laboratory tests (¶IV. F), admissions examination (¶V. A (4)) and medications (¶V. A (5)). Additionally, the Judgment directs defendants to periodically conduct audits of the records, inspections of the medical facilities and equipment, and such personal observation of procedures and discussion with medical staff and inmates as the auditors deem appropriate to determine whether necessary medical care is being provided, and to issue reports on their findings. (¶V. B.) (A47-48.)

## ARGUMENT

### POINT I

THE RECORD FULLY DEMONSTRATES THAT DEFENDANTS' SYSTEM OF MEDICAL CARE IS SO SERIOUSLY INADEQUATE AS TO CAUSE UNWARRANTED SUFFERING BY THE PLAINTIFF CLASS IN VIOLATION OF THEIR CONSTITUTIONAL RIGHTS.

The District Court's extensive and carefully balanced findings of fact establish that, in most crucial respects, the medical care system at Bedford Hills is so disorganized and ill-administered as to routinely and repeatedly deny the plaintiff class the treatment required for serious medical problems. In each instance, the court determined both that the procedures for delivering care were designed in a manner certain to deny medical attention when needed and that, in fact, these defects had in many cases subjected women to needless suffering and risk of serious harm. Accordingly, the District Court was compelled to hold that the prison's system of medical care is so seriously inadequate as to cause unwarranted suffering, and hence is unconstitutional. Bishop v. Stoneman, 508 F.2d 1224, 1226 (2d Cir. 1974). See also Cruz v. Ward, No. 77-7403, slip op. 4397, 4404 (2d Cir. June 23, 1977).

The relevant law is neither complicated nor in dispute. The Supreme Court, adopting this Circuit's long-standing formulation of the constitutional standard, has only recently ruled that "deliberate indifference to serious medical needs of prisoners [violates] the Eighth Amendment." Estelle v. Gamble, 429 U.S. 97,



104 (1976).<sup>\*</sup> The Court relied on several factors which have been repeatedly noted in scrutinizing inmate medical claims. First, and most significantly, inmate are entirely dependent upon their custodians for all their medical needs. Estelle, 429 U.S. at 103.

An individual incarcerated . . . becomes both vulnerable and dependent upon the state to provide certain simple and basic human needs . . . Medical care is another such need . . . restrained by the authority of the state, the individual cannot himself seek medical aid or provide the other necessities for sustaining life and health.

Fitzke v. Shappell, 468 F.2d 1072, 1976 (6th Cir. 1972) (original emphasis).

See also Cruz v. Ward, slip op. at 4404; Mills v. Oliver, 367 F. Supp. 77, 79 (E.D.Va. 1973). As a result the government has an affirmative "obligation to provide medical care for those whom it is punishing by incarceration." Estelle, 429 U.S. at 103.

Second, our society's evolving minimal standards of decency not only reject the whip and the screw as machines of punishment but also forbid the infliction or perpetuation of unnecessary physical pain and suffering as a permissible concomitant of a sentence of confinement. Edwards v. Durcan, 355 F.2d 993, 994 (4th Cir. 1966); Newman v. Alabama, 503 F.2d 1320, 1329 (5th Cir. 1974). As the Supreme Court explained, in the worst cases, failure to provide needed medical care "may actually produce physical 'torture or a lingering death,'" the precise evils prompting enactment of the Eighth Amendment. Estelle, 429 U.S. at 103. Yet even "[i]n less serious cases, denial of medical care may result in pain

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<sup>\*</sup> Although other Circuits later adopted the "deliberate indifference" standard, see 429 U.S. at 106, n.14, this Court was the first to formulate the legal standard in those terms, having used it since 1970. See Martinez v. Mancusi, 443 F.2d 921, 924 (2d Cir. 1970); Corby v. Conboy, 457 F.2d 251, 254 (2d Cir. 1972).

and suffering which . . . is inconsistent with contemporary standards of decency." Id.

Likewise, the Court noted that the deprivation of medical care does not "serve any penological purpose." Id. Indeed, it is counterproductive of such goals as rehabilitation, see Pugh v. Locke, 406 F.Supp. 418 (M.D.Ala. 1976), and, in any case, falls outside the sphere of correctional expertise to which federal courts have been careful to defer. Newman v. Alabama, 503 F.2d at 1328-30.

Finally, the Court explained that the "deliberate indifference" standard draws a clear line between mere complaints of medical misjudgment, relegated to the state malpractice remedy, and charges of medical deprivation. Estelle, 429 U.S. at 105-106. Yet, it is sufficiently flexible to cover the entire range of such deprivations suffered at the hands of either medical or correctional personnel in their operation of the medical system, for "[r]egardless of how evidenced, deliberate indifference to a prisoner's serious illness or injury states a cause of action under §1983." Id. at 105.

Prison health care has often been challenged on an institutional rather than individual level. In such cases, courts, of necessity, examine not only the specific individual deprivations, but also the systemic deficiencies, from sick call procedures through laboratory and infirmary arrangements, which subject the entire confined population to harm.\*

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\* See Finney v. Arkansas Board of Correction, 505 F.2d 194 (8th Cir. 1974); Newman v. Alabama; Gates v. Collier, 501 F.2d (Footnote continued on next page)



This Court has already twice mandated such systematic analysis. Bishop v. Stoneman involved claims very similar to those proven here, including delayed access to a physician, delays in performing and reporting diagnostic tests, denial of followup care and infrequent physician attendance in the prison hospital. The Court held that such a pattern of non-delivery of needed medical care amounts to constitutionally impermissible indifference to inmate medical needs. 508 F.2d at 1225. The Court further ruled that equitable relief would be available if plaintiffs demonstrated that "the medical facilities are so wholly inadequate for the prison population's needs that suffering would be inevitable." Id. at 1226. Likewise Cruz v. Ward, citing the District Court opinion in this case, confirmed that deliberate indifference is established on an institutional level by proof, as here, that "the prison's system of medical care is so seriously inadequate as to cause unwarranted suffering." Slipop. at 4404. These cases recognize that "to secure the individual constitutional right

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(Footnote continued from last page)

1291 (5th Cir. 1974); Holt v. Sarver, 442 F.2d 304 (8th Cir. 1971); Palmigiano v. Garrahy, #74-172 (D.R.I. Aug. 10, 1977); Mitchell v. Untreiner, 421 F.2d pp. 886 (N.D.Fla. 1976); Martinez Rodriguez v. Jimenez, 409 F.Supp. 582 (D.P.R.), stay denied, 537 F.2d 1 (1st Cir. 1976); Campbell v. Magruder, #1462-71 (D.D.C. Nov. 5, 1975); Miller v. Carson, 401 F.Supp. 835 (M.D.Fla. 1975); Costello v. Wainwright, 397 F.Supp. 20 (M.D.Fla. 1975), aff'd., 525 F.2d 1239 (5th Cir. 1976), order rev'd. for lack of three-judge court, 539 F.2d 547 (5th Cir. 1976) (en banc), latter order rev'd., 97 S.Ct. 1191 (1977); Cudnik v. Kreiger, 392 F.Supp. 305 (N.D. Ohio 1974); Battle v. Anderson, 376 F.Supp. 402 (E.D. Okla. 1974); Inmates of Suffolk County Jail v. Eisenstadt, 360 F.Supp. 676 (D. Mass. 1973); Hamilton v. Landrieu, 351 F.Supp. 549 (E.D. La. 1972); Collins v. Schoonfield, 344 F.Supp. 257 (D. Md. 1972); Hamilton v. Schiro, 338 F.Supp. 1016 (E.D. La. 1971); Jones v. Wittenberg, 330 F.Supp. 707 (N.D. Ohio 1971), aff'd. sub nom. Jones v. Metzger, 456 F.2d 854 (6th Cir. 1972); Joiner v. Pruitt, #475-166 (Ind. Super. Ct. Feb. 21, 1975); Wayne County Jail Inmates v. Wayne County Board of Commissioners, C.A. #173217 (Mich. Cir. Ct. July 28, 1972); Jackson v. Hendrick, No. 71-2437 (Penn. Ct. Common Pleas, April 7, 1972).

adequate medical programs are constitutionally required." Holland v. Donelon, 2 Pris. L. Rptr. 375, 377 (E.D.La. 1973).

In this as in other class settings, then, the question is whether the prison authorities maintain "a medical program so organized, staffed and administered as to assure that medical care will be available with reasonable promptness to any inmate who requires it." Smith v. Hongisto, 2 Pris. L. Rptr. 284, 286 (N.D.Cal. 1973). See also Appellants' Brief at 43 ("the state has . . . [an] obligation [to] provide a program which is reasonably suited to meet the needs of the resident population so that human suffering is not inevitable."). The record here fully confirms that defendants' medical program is not so suited and that women routinely and repeatedly suffer unnecessarily as a result.

Courts have identified three kinds of medical deprivation as constitutionally unacceptable -- denial of access to a physician, failure to deliver prescribed care and subjection to correctional requirements or medical procedures hazardous to health. This case involves all three.

First, as noted by the District Court here, "are those cases which have held unconstitutional denied or unreasonably delayed access to a physician for diagnosis and treatment of physical conditions which, although not life-threatening or likely to result in permanent disability, cause discomfort" (A- 9 ). Typical is the holding of this Court in Corby v. Conboy, 457 F.2d 251, 254 (2d Cir. 1972), that denial of access to a physician for diagnosis and treatment of a serious nasal problem is deliberate indifference violative of an inmate's constitutional rights. Similarly the court



in Miller v. Carson, 401 F.Supp. 835, 878 (M.D.Fla. 1975), held shocking and constitutionally unacceptable a two-week delay in access to a physician for an earache which proved to have resulted from an ear infection. See also cases cited at p. 64 infra.

The second group of cases are those in which the treatment prescribed by a doctor is not administered when and as directed. Unlike a malpractice claim which questions the propriety of the prescription chosen, these cases focus solely on the impropriety of non-compliance with the doctor's orders whatever they may be. Indeed, this Court first introduced the "deliberate indifference" standard in a case, twice cited approvingly by the Supreme Court in Estelle,\* in which the inmate complained that both the warden and the prison doctor had improperly ignored the surgeons' orders for bed rest and pain medication. Martinez v. Mancusi, 443 F.2d 921 (2d Cir. 1970), cert. denied, 401 U.S. 983 (1971). In the same vein, courts have repeatedly held unconstitutional the failure to promptly provide prescribed medication, diagnostic tests, special diets, specialist examinations, surgery, and followup appointments.\*\*

The third set of cases proscribes the exposure of inmates to conditions or equipment which are themselves dangerous or aggra-

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\* 429 U.S. at 104, nn. 10 and 12.

\*\* See, e.g., Campbell v. Beto, 460 F.2d 765 (5th Cir. 1972); Bishop v. Stoneman; Wright v. Twomey, 3 Pris. L.Rptr. 306 (7th Cir. 1974); Sawyer v. Sigler, 320 F.Supp. 690 (D.Neb. 1970), aff'd, 445 F.2d 818 (8th Cir. 1971); Freeman v. Lockhart, 503 F.2d 1016 (8th Cir. 1974); Miller v. Carson.

vate physical ailments.\*

The extensive findings of fact in the instant case demonstrate that defendants operate a medical system which routinely subjects the plaintiff class to all three kinds of medical deprivation.\*\*

First and foremost, defendants have created and maintained for years a procedure for processing inmate requests for medical care, known as "lobby clinic," which necessarily denies women with serious ailments access to needed treatment. Because medication is administered at the same time that requests for care are

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\* See, e.g., Haines v. Kerner, 404 U.S. 519 (1972); Wilbron v. Hutto, 509 F.2d 621 (8th Cir. 1975) (cited approvingly in Estelle, 429 U.S. at 105, n.12); Thomas v. Pate, 493 F.2d 151 (7th Cir. 1974) (Estelle, 429 U.S. at 104, n.10); Miller v. Carson; Newman v. Alabama, 503 F.2d at 1331.

\*\* Defendants' major argument is that the District Court erred in holding the system found at Bedford Hills to be constitutionally inadequate (Brief at 1, 41). Yet at several points, they seem to question some of the District Court's findings of fact concerning the repeated and systematic nature of the medical deprivations (Id. at 42, 43, 45, 49). To succeed, they must, of course, establish that these findings are "clearly erroneous," Fed. R. Civ. P. 52(a), that is, they must leave this Court "with the definite and firm conviction that a mistake has been committed." Zenith Radio Corp. v. Hazeltine Research, Inc., 395 U.S. 100, 123 (1969).

Their challenge must fail for several, basic reasons. First, as the District Court noted (A-13,14), and as set forth previously in this brief, the findings are supported by a large number of instances throughout the record, although the opinion, for brevity's sake, necessarily only mentions a few typical examples. Second, the District Court found that the medical records and the instances of medical deprivation presented by plaintiffs were representative and that defendants failed to introduce any other individual records to contradict the showing of representativeness, see p. 6-7, supra. Further, plaintiffs supplemented the individual examples in several instances with statistical evidence. Finally, and most crucially, defendants ignore the Court's detailed analysis in each instance of the built-in deficiencies in established procedures which confirm that the individual deprivations presented are not only representative but inevitable products of systemic inadequacies.



received, the lobby clinic is crowded and disorderly and the nurse has only a few seconds to inquire as to the medical need. Yet even this minimal encounter is totally inadequate. The inmate must speak to the nurse through a barred, locked window in the immediate presence of a guard. Neither physical examination of the relevant parts of the body nor simple diagnostic tests are possible, the privacy needed for communication of delicate information is entirely lacking, and the medical record is unavailable. As a result, the nurse simply cannot make any meaningful evaluation of the inmate's medical complaint. Moreover, the encounter goes, in essence, unrecorded, and doctor's appointments are, in any case, scheduled by a different nurse.

The inevitable result of this process is that persons with serious medical problems do not see a doctor when needed. Contrary to defendants' claim, the District Court did not base its finding, that the lobby clinic procedure results in substantial delay or denial of access to a physician for significant illnesses, upon five isolated instances. Rather, as set forth above (see pp. 18-23 , supra), the examples supporting the finding are legion and spread throughout the record. Phyllis Hapeman, who had already suffered a two-day delay despite nurse-verified blindness and later was found to have glaucoma, was on two later occasions denied access to any doctor for 4 and 3 weeks respectively, despite numerous complaints of pain and vision problems. Although Rosemary Cutshaw had a recorded history of cardiac arrest, she was not

seen for two weeks despite six noted complaints of chest and back pain. Likewise Rosezanna Vega saw no doctor for 17 days in the face of repeated complaints of chest and back pains. No pelvic examination was conducted for four weeks after Cleo Bacon miscarried. Iris Capella was not examined for over a month despite complaints of abdominal pain and expressed fears of IUD complications. Candida Rivera did not see a doctor for eight days after being struck in the head. Paulette Blackstock was not seen for five months despite eye pain and blurred vision and then was told of possible tissue growth on the eye disc. Theresa Durante did not see a gynecologist through two and a half months of lobby clinic complaints of large vaginal blood clots. Louise Johnson, known to defendants to have already suffered some permanent vision loss, was made to wait two weeks for a doctor's appointment although the lobby clinic notebook was to "remind" the scheduling nurse that it was an emergency.

As a matter of constitutional right "every inmate in need of medical attention [must] be seen by a qualified physician when necessary." Finney v. Arkansas Board of Correction, 505 F.2d at 204; Newman v. Alabama, 349 F.Supp. 278, 289 (M.D.Ala. 1972); Jones v. Wittenberg, 330 F.Supp. at 718; Smith v. Hongisto, 2 Pris.L. Rptr. at 287.\* Delays of several weeks to several months in the

\* See also United Nations Standard Minimum Rules for Treatment of Prisoners, Rule 25(1), in ABA Commission on Correctional Facilities and Services, Medical and Health Care in Jails, Prisons, and Other Correctional Facilities 7 (3d ed. 1974) (hereinafter ABA Compilation); American Bar Association, Standards Relating to the Legal Status of Prisoners (Tentative Draft), 14 Am. Crim. L. Rev. 474-75 (1977); National Sheriffs' Association, Handbook on Jail Programs, 13-14 (1974); Illinois County Jail Standards, Ch. XIV, §B, in ABA Compilation at 49-50.



evaluation and treatment of eye infection chest pains, miscarriages, eye pains and blurred vision, vaginal blood clots, head injuries, and the like as, found by the District Court here, are constitutionally unacceptable. See Bishop v. Stoneman (constitutional claim stated in claims of a three-week delay in seeing a doctor for weight loss, ten-day delay for injured shoulder, one week delay in separate cases for new orthopedic shoes, severe stomach pains, and vomiting, and three-day delay in seeing doctor for temperature and vomiting of blood) and Williams v. Vincent, 508 F.2d 581 (2d Cir. 1974) (denial of pain medication for 22 days after stitching of ear would warrant federal relief).<sup>\*</sup> And, when as here, the result -- denial of access to a doctor -- is unconstitutional, "the deficiency which spawns the infirmity" -- the lobby clinic procedure -- must similarly be condemned. Newman

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<sup>\*</sup> See also Westlake v. Lucas, 537 F.2d 857 (6th Cir. 1976) (denial of access to doctor for eight days for stomach pains and abdominal distress is constitutional violation even if only unnecessary pain, rather than permanent injury, is shown); Shannon v. Lester, 519 F.2d 76 (6th Cir. 1975) (remanding for proper jury instructions on damage claim for pain and suffering resulting from five-hour delay in transportation to emergency room of drunken driver); Runnels v. Rosendale, 499 F.2d 733 (9th Cir. 1974) (denial of aspirin for five days for post-operative pain); Fitzke v. Shappell, and Hughes v. Noble, 295 F.2d 495 (5th Cir. 1961) (denial of access to physician for car accident injuries during 12 and 13 hours of confinement respectively); Blanks v. Cunningham, 409 F.2d 220 (4th Cir. 1969) and Redding v. Pate, 220 F.Supp. 124 (N.D.Ill. 1963) (epileptics denied physician care); Newman v. Alabama, 349 F.Supp. at 283-84 (delays for weeks and months in doctor examination for serious but non-emergency conditions causing needless suffering). Cooper v. Morin, 50 A.D. 2d 32 (4th Dept. 1975) (denial of vaginal examination for heavy bleeding and discharge, denial of physician examination for coughing up blood, three-day wait to see doctor for fever and stomach pains and for infected sore); and other cases cited approvingly in Estelle, 429 U.S. at 105, n.11.

v. Alabama, 503 F.2d at 1331. As recounted above, the record here fully confirms the District Court's conclusion that the many instances of substantial delay in care for serious medical problems are representative and inevitable products of a physician referral system which is obviously "so seriously inadequate as to cause unwarranted suffering." Cruz v. Ward, at 4404.\*

Second, the findings of fact establish that defendants' system repeatedly denies patients the medical care prescribed for them. In four crucial categories, the Court found repeated non-compliance with medical orders resulting in a failure to diagnose or treat significant pathology. Again, the Court detailed the built-in administrative deficiencies rendering those deprivations inevitable.

Although as defendants contend many laboratory tests are done at Bedford Hills, the District Court found on undisputed facts that in a significant number of cases orders for diagnostic tests are not performed. Thus urine cultures needed to insure that bladder

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\* Defendants at times appear to argue that, because the staffing and care at institutions reviewed in other cases was even worse than at Bedford Hills, their care must be acceptable. (Brief at 56). Similarly, they seem to contend that, because Bedford Hills has a regular health staff and conducts lobby clinic twice a day, the system must be constitutionally adequate and the District Court must have improperly employed an optimum standard in sustaining plaintiffs' claims. (Id. at 42, 54).

This Court has already rejected this argument in Rhem v. Malcolm, 507 F.2d 333, 337 (2d Cir. 1974), noting that while "[i]t is true that in some [other cases] conditions were worse in many respects. . . than those in the Tombs . . . this proves only that some jails are even less tolerable than the Tombs, not that the district judge here was necessarily in error." See also Palmigiano v. Garrahy, slip op. at 72-73. And, as the District Court properly noted here, if the constitutionally relevant result is the same -- namely, the denial of necessary medical care for substantial periods causing unwarranted human suffering -- then it is of no constitutional significance that the causes are more obviously egregious in other places. Surely, no court would countenance a limitation of inmates to one

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infections had been treated and that no danger to the kidneys remained were simply not done for Ms. Blackstock or Ms. Booker, and not available to the doctor treating Ms. Franklin and Ms. Davis. One woman with a month's neck pains and headaches and a history of rheumatic fever did not receive the ordered blood test for the last three recorded months, and a sample for a simple blood count, ordered for another women's tubal infection, was not even drawn for six weeks. Thyroid tests ordered on an immediate basis were not done for 8 months. And most strikingly, Pap smears were repeatedly not done for many months although four cases of cancer were discovered at the prison in one year.

Defendants' chief physician was aware of this systemic non-performance of tests and ordered the laboratory technician to change her notification system. Yet, the directive went ignored and the admittedly hit-or-miss system was perpetuated.

Where tests were finally performed, significant pathology revealed by the results were frequently not treated. Despite an extraordinarily abnormal liver function test, and later complaints of bruising related to a history of liver disease, Angie Vasquez did not see a doctor for seven weeks. Mary Reed did not see a doctor for a month after evidence of internal bleeding was revealed by positive stool samples. Serious vaginal inflammations, which could increase the risk of cancer later in life, went untreated for months in several instances.

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(Footnote continued from last page)  
cold sandwich per day simply because defendants testify that they have a full-time professional chef and the most modern cooking facilities.

Yet even where a doctor was seeking to treat a diagnosed condition, his order for a further examination would frequently go unheeded. Once again plaintiffs presented numerous individual instances as well as statistical proof of the defect. And, here too, it was established that inadequate record-keeping and notification procedures assured that ordered medical appointments would frequently be denied.

Finally, in every case of diagnosed hypertension presented to the court, nurses failed to perform the regular blood pressure readings required to monitor the treatment. The chief physician admitted full awareness of this non-compliance, which he attributed to insufficient staff.

Since a doctor's order is the clearest statement of the need for medical care, failure to perform and review diagnostic tests or to provide follow-up examinations and other treatment mandated by a physician is the clearest example of constitutionally impermissible indifference to inmates' medical needs. Bishop v. Stoneman (X-rays and blood tests); Campbell v. Beto (prescribed medication denied to cardiac patient for 12 days); Mitchell v. Chester County Farm Prison, 426 F.Supp. 271 (E.D.Pa. 1976) (four-day delay in providing epileptic with prescribed medication, resulting in seizure); Monroe v. Bombard, 422 F.Supp. 211, 214-15 (S.D.N.Y. 1976) (correction rule interfering with growth of beard prescribed as treatment for skin condition); Sawyer v. Sigler (failure to provide both medication in uncrushed form and an ordered specialist examination); Miller v. Carson (three-week delay in returning patient to



hospital clinic for follow-up appointment to adjust arm cast); and other cases cited in Estelle, 429 U.S. at 105, n.12, and at p. 60, supra. In short, prisoners are guaranteed "the right to the treatment prescribed." South Carolina Department of Correction, The Emerging Rights of the Confined, 149-52 (1972).<sup>\*</sup> They are likewise entitled to protection from a medical system which, because of "disorganized lines of therapeutic responsibility," inadequate record-keeping or other procedural deficiencies, is "pregnant with the possibility of non-compliance." Newman v. Alabama, 503 F.2d at 1331. The record confirms that defendants' established procedures for ordering, performing and reviewing diagnostic tests and for scheduling physician appointments have a built-in guarantee of repeated non-compliance with medical orders resulting in a significant number of cases in undiagnosed or untreated serious ailments.

Third, the record shows that for years defendants have knowingly been exposing the entire plaintiff class to an x-ray machine which improperly irradiates the entire body. Significantly, defendants fail to mention this systemic health hazard in describing their admission procedures and do not challenge the holding of unconstitutionality (Brief at 12-16, 60), perhaps

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<sup>\*</sup> See also American Medical Association, Standards for the Accreditation of Medical Care and Health Services in Jails, 1-3 (1977); National Advisory Commission on Criminal Justice Standards and Goals, Standard 2.6, in ABA Compilation at 16-17; Association of State Correctional Administrators, Uniform Correctional Policies and Procedures, in ABA Compilation at 41; Illinois County Jail Standards, Ch. XIV, §B(6), (7), in ABA Compilation, at 50-51; Nebraska State Bar Association, Minimum Standards for Local Criminal Detention Facilities, §12(8), p. 184-85 (Feb. 1977).

aware how clearly their conduct reveals systematic and knowing indifference to the health and well-being of their dependent charges. Newman v. Alabama, 503 F.2d at 1331.

Finally, defendants maintain an infirmary system which demonstrates all three of the deficiencies condemned by federal courts. Because of the isolation, inmates placed in sick wing are deprived of the bed rest and close medical observation which the medical staff determined they need. Further these women, who are known to have more medical problems than other inmates, are placed in a physical structure and subjected to such restrictions as to effectively deny them access to medical attention when needed and increase the hazards to their health.

Again, the basic structure is clear. Women running high fevers, returning from hospitalization, experiencing epileptic seizures, or suffering similar conditions requiring rest and care are placed in individual rooms on locked corridors on which neither medical nor correctional staff are stationed. No call system exists for communicating medical needs to the staff. Several of the rooms are themselves locked, thus precluding even verbal requests for help.\* The closest officer is in a station across a lobby from the end of the corridor which can be covered, at the officer's discretion, with a solid door blocking sound and vision. The closest medical assistance is in the ambulatory care clinic on the other side of yet another solid, continuously-locked door on

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\* Although at time of trial only 4 of the 19 rooms on the sick wing corridors were locked, now the entire set of 8 rooms still available for this purpose are locked. See p. 44, supra.



the first floor. No medical equipment or emergency supplies are located either on the sick wing corridors or in the officer's station closest to the infirmary. Although nurses and officers make several rounds during the day, there is at most one nurse on duty at night and correction rounds are at best infrequent at that time.

The net result of the system is frequent denial of necessary medical care to sick patients. Women having trouble breathing or experiencing convulsive seizures must rely on the chance that sick inmate neighbors will hear them and come to their aid. Officers regularly do not respond to shouting and banging loud enough to awaken an entire corridor of inmates. When they do respond, they often will simply identify the problem and then depart to contact the nurse, leaving the patient again with only inmates in attendance. In one case, the officer had to obtain the presence of a sergeant even to open the door of one locked inmate suffering a seizure. Finally, even after the nurse's ultimate arrival, treatment may be further delayed since necessary equipment or medication are not present.

None of the testimony and documentary evidence concerning the numerous individual incidents in sick wing was contradicted by defendants at trial, and the court's findings concerning the structural communication and observation problems are fully supported. Defendants are thus wholly inaccurate in stating (Brief at 43-44) that the District Court relied simply on two incidents in finding serious lack of communication and observation in sick wing.

Sick infirmary patients, no less than the rest of the inmate population, are entitled to have reasonable access to medical attention commensurate with the urgency of their condition, the observation and care prescribed by their doctor, and protection from conditions hazardous to their health. Courts have repeatedly required that prisons provide appropriately located, staffed and designed infirmary facilities to insure proper care for patients deemed to require such treatment. Finney v. Arkansas, 505 F.2d at 718; Gates v. Collier, 501 F.2d at 1303; Palmigiano v. Garrahy, slip op. at 48-49; Martinez Rodriguez v. Jimenez; 409 F.Supp. at 589, 597; Miller v. Carson, 401 F.Supp. at 878; Battle v. Anderson, 376 F.Supp. at 434; Hamilton v. Landrieu, 351 F.Supp. at 550; Newman v. Alabama, 349 F.Supp. at 287.\* The District Court here was fully warranted in its determination that the infirmary at Bedford Hills was designed and staffed in a manner so inadequate as to insure denial of necessary care and unwarranted suffering.

In the face of this record, the District Court was compelled to conclude that the medical system at Bedford Hills was constitutionally inadequate. Each of the deficiencies identified in the court's findings has been previously subjected to judicial disapproval. Second, the pitfalls identified are of such a nature "as to render large-scale improvident treatment inevitable." Third, "the record

\* See also AMA, Standards for Accreditation, supra at 13-14, 20-21; ABA Standards, supra, 14 Crim. L. Rev. at 479-81; American Public Health Association, Standards for Health Services in Correctional Institutions, 16-18 (1976); Illinois County Jail Standards, Ch. XIV, §B(7), in ABA Compilation at 51.



is replete with countless examples of inmates who were subjected to incalculable discomfort and pain as a result of the lack of medical care. These examples fortify the conclusion that deficiencies were not isolated and bespeak of callous indifference to the welfare of inmate-patients." Newman v. Alabama, 503 F.2d at 1332. Indeed, here, there was evidence not only of incalculable discomfort and pain, but also of substantial risk of serious injury. Federal courts need not wait until an epileptic chokes on her tongue, cancer develops from untreated cervical inflammations or an inmate suffers a heart attack while waiting for the lobby clinic nurse to communicate her chest pains to the doctor. Palmigiano v. Garrahy, slip op. at 42-43. In the face of long-standing systemic inadequacies, repeated individual suffering and substantial risk of serious injury, the District Court properly concluded that defendants were unconstitutionally depriving the inmate class of necessary medical care and that injunctive relief was necessary.

#### POINT II

THE JUDGMENT, WITHOUT IN ANY WAY INTERFERING WITH THE PROFESSIONAL MEDICAL DISCRETION OF DEFENDANTS' HEALTH STAFF, REASONABLY ADDRESSES THE PROCEDURAL DEFICIENCIES AT BEDFORD HILLS PROVEN TO RESULT IN UNCONSTITUTIONAL DEPRIVATION OF MEDICAL CARE.

Without citation of authority and ignoring the fact that the District Court rejected several significant limitations proposed by plaintiffs, defendants contend that the Judgment ex-

ceeds both the trial proof and the court's findings and constitutes an unwarranted interference with the administration of the Bedford Hills medical program. The claim must be rejected, since the District Court clearly acted judiciously and with restraint in exercising its broad discretion to frame equitable relief for class-wide constitutional violations.

Once, as here, a constitutional violation is established, "the scope of a district court's equitable powers to remedy past wrongs is broad, for breadth and flexibility are inherent in equitable remedies." Milliken v. Bradley, 97 S.Ct. 2749, 2757 (1977); Swann v. Charlotte-Mecklenburg Board of Education, 402 U.S. 1, 15 (1971). The nature of the remedy "is determined by the nature and scope of the constitutional violation," Milliken, 97 S.Ct. at 2757, and must be "wholly commensurate" with the scope of the violation. Hills v. Gautreaux, 425 U.S. 284, \_\_\_, (1976). See also Newman v. Alabama, 503 F.2d at 1332-33. A remedy is not excessive as long as it is reasonably tailored to rectify "the condition which offends the Constitution." Milliken, 97 S.Ct. at 2758. Accordingly, appellate courts repeatedly defer to the "wide discretion accorded to district courts in the framing of remedies." Hart v. Community School Board of Brooklyn, 497 F.2d 1027, 1032 (2d Cir. 1974) (indicating approval of broad order for remedial action by housing, transit recreational and police, as well as educational, authorities for school discrimination violation).\* In so deferring, courts

\* See also Milliken, 97 S.Ct. at 2758 (approving compensatory, remedial educational programs for an entire school district although the constitutional violation was discriminatory pupil assignment and instructional programming is normally left to professional educators); Hills v. Gautreaux (approving metropolitan-wide housing relief though constitutional violations had occurred solely within

(Footnote continued on next page)



repeatedly stress that "within the bound of rationality, 'the framing of decrees should take place in the District rather than in Appellate Courts.'" Coalition for Education, 495 F.2d at 1094, and that equitable decrees should be reversed only on a clear showing of abuse. Id. See also Hart v. Community School Board; Vulcan v. Civil Service Commission, 490 F.2d 387 (2d Cir. 1973); Chance v. Board of Examiners, 458 F.2d 1167 (2d Cir. 1972).

This Court has already noted that many decisions concerning prison conditions have mandated extensive changes in prison practices, from the hiring of dozens of guards, through the building of new or substantial alteration of old facilities, to the appointment of a prison ombudsman and creation of a Department of Correction. Rhem v. Malcolm, 507 F.2d 333, 340-41 and nn. 15-20 (2d Cir. 1974).<sup>\*</sup> Indeed, this Court has affirmed that, under appropriate circumstances, federal equity courts could take such "drastic action" as ordering the closing of an entire jail, or even directing release of prisoners, absent compliance with constitutional requirements. Id. at 340-41; Detainees of the Brooklyn House of Detention for Men v. Malcolm, 520 F.2d 392

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city limits); Coalition for Education in District One v. Board of Elections, 495 F.2d 1090, 1094 (2d Cir. 1974) (affirming the voiding of entire proportional representation election though impact of tainted votes on certain candidates uncertain).

<sup>\*</sup> For subsequent cases involving comparable orders, see Newman v. Alabama; Gates v. Collier; Finney v. Arkansas Board of Correction; Palmigiano v. Garrahy (Human Rights Committee of private citizens established to monitor compliance with extensive constitutional standards); Martinez Rodriguez v. Jimenez (requiring closing by fixed date and setting firm standards for conduct until closure); Pugh v. Locke, (committee of private citizens to monitor institutional standards for entire prison system); Miller v. Carson, (permanent ombudsman).

(2d Cir. 1975).<sup>\*</sup> Likewise, it confirmed that courts are empowered to employ the less drastic approach of ordering "an expensive, burdensome or administratively inconvenient remedy" when, as here, the affected government function must be maintained. Rhem, 507 F.2d at 341, n. 19. In fact, in class actions affecting prison health care, courts have employed a broad range of remedies, from specifying the number and qualifications of health staff to be hired, Gates v. Collier; Miller v. Carson, and mandating compliance with federal Medicare standards, Newman v. Alabama, 349 F.Supp. at 287, to directing construction of new facilities, Hamilton v. Landrieu; Battle v. Anderson.

Without question the District Court here had to insure continuation of medical service to the women at Bedford Hills. But it had already determined that the health and correctional administrators through the years of litigation were unwilling or unable to make the changes necessary to insure constitutionally acceptable access to and delivery of medical treatment. It therefore was compelled to order equitable relief which would rectify the long-standing inadequacies, yet did so in a manner which was least intrusive upon administrative options and left wholly unaffected defendants' professional medical discretion.\*\*

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<sup>\*</sup> See also Costello v. Wainwright (enjoining further admissions to entire prison system to insure adequate medical care).

<sup>\*\*</sup> Defendants argue that even if the District Court was correct in finding constitutional defects, it was improper to order relief because "without proof that more could be accomplished with the existing staff, the Court could not find defendants guilty of unconstitutional conduct" (Brief at 59). No verdict of guilty, of course, was rendered in this civil action. More pertinently, no individual liability in money damages was ever sought in this case. The standard set forth in Wood v. Strickland, 420 U.S. 308 (Footnote continued on next page)



Examination of the major provisions of the Judgment compels this conclusion. With regard to physician access, the District Court had determined that as a result of a screening procedure which was inadequate in terms of location, operation, privacy, equipment, record-keeping, referrals and time delays, the plaintiff class had repeatedly been denied access to a physician for diagnosis and treatment of physically painful and serious ailments. The District Court did not wish to mandate, as other courts had done, see, e.g., Jones v. Wittenberg, 330 F.Supp. at 718 ; Martinez Rodriguez v. Jimenez, 409 F.Supp. at 596-97; that all inmates have access daily to sick call conducted by

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(1975), and O'Connor v. Donaldson, 422 U.S. 563 (1975), for holding public administrators personally liable for constitutional deprivations suffered by their charges, is thus wholly inapplicable, as is the one case cited by defendants for this proposition. (Brief at 59). This action sought, and the court granted, only declaratory and injunctive relief against the relevant correctional and health care administrators. The court found that they are the public officials responsible for the delivery of medical care at Bedford Hills and have created, maintained and are aware of the procedures found defective. The court consequently enjoined them, their successors in those positions, and all employees and agents acting in concert with them, to insure rectification of the constitutional defects. This is, of course, the form of relief provided in every class action cited in this brief as well as in innumerable other federal cases remedying constitutional violations.

In a similar vein, defendants object to the Judgment because implementation might cost money and claim inability to comply as a result. In fact, their proposed judgment had conditioned enforcement of the major provisions upon a substantial increase in funding and staffing. (A-67-68 ). However, this Court has already three times explicitly held that inadequate resources can never be an excuse for depriving prisoners of their constitutional rights. Rhem v. Malcolm, 527 F.2d 1041, 1043-44 (2d Cir. 1975); Detainees of the Brooklyn House of Detention, 520 F.2d at 399; Rhem v. Malcolm, 507 F.2d at 341, n.20. See also Martinez Rodriguez v. Jimenez, 537 F.2d 1, 3 (1st Cir. 1976); Jackson v. Risher, 404 F.2d 571, 580 (8th Cir. 1968) (Judge, now Justice, Blackmun).

a physician, since defendants had repeatedly stressed at trial their professional preference for a system of nurse screening of requests for a physician examination. On the other hand, given the overwhelming proof, the court could not simply permit continuation of the existing sick call screening pending possible future allocation of more nurse staff items, as defendants had proposed (Defendants' Proposed Judgement, A- 66-68; Memorandum in Support of Plaintiffs' Proposed Judgment at 14-15. Seeking to maximize administrative discretion consistent with constitutional requirements, the District Court provided defendants with the option of either having all inmates seen by a physician no later than the next day (or within two days if the request comes on a Saturday), or employing a screening procedure meeting the minimum standards required to insure reasonably prompt access. Judgment III(A) and (B) (A 42-43 ). See Smith v. Hongisto, 2 Pris. L. Rptr. at 287.

Defendants complain that the specific elements of screening set forth are unfounded and excessive. In doing so they ignore the evidentiary record and findings on this point. The District Court found that the combination of medication dispensing and sick call screening functions was the primary cause of the chaotic, impersonal and brief nature of the screening encounter. Accordingly, the Court simply ordered that screening be separated in time and place\* from medication administration,

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\* Defendants question the need for separate facilities. Yet the evidence before the Court was that the presence of medications in the screening room led to the locking of the facility which the Court determined was the major obstacle to adequate screening.



without in any way interfering with defendants' administrative discretion to choose the time and place for each function and the procedures for medication administration. Judgment, III(B)(1)(A-43).\*

Defendants allege that Part III(B)(5), requiring an opportunity for confidential communication and physical examinations, "is totally unwarranted, since this has always been the policy at Bedford Hills," and that "[t]he materials required by Part III(B)(6) have always been available" (Brief at 67). Whatever defendants claim was their policy, the Court's explicit findings establish that in fact, the lobby clinic procedure prevents confidential communication, physical contact and use of available materials.\*\*

It is also hard to comprehend defendants' challenge to the Judgment's requirement, III (B)(7), that all screening encounters be recorded in the inmate's individual record. The court found record-keeping to be the "fatal defect" in the screening process since crucial information is not recorded or trans-

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\* Here, as in many other instances throughout the Judgment, the District Court really had very little choice as to the nature of the remedy. Having found the combination of screening and medication administration to be inadequate, for example, the court could only direct the defendants to cease such conduct. The fact that the Judgment was framed in terms of a mandate to separate, rather than a prohibition against combining, is, of course, a mere difference in form. At many points, defendants balk at an affirmative provision in the Judgment which is no more than a direction to stop and reverse the practice held unconstitutional.

\*\* Significantly, the District Court framed its order in this regard to maximize defendants' discretion and to avoid any infringement on medical judgment. Thus, defendants may determine when "the proximate presence" of a guard is "necessary," the nature, size and location of the "facility" to be used, and when a physical examination is "relevant." III(B)(5). Likewise, apart from specifying a few of the most basic diagnostic tools, such as a thermometer and flashlight, which the experts explained would be needed for reasonable screening, the Judgment leaves the determination of what equipment, medication and supplies are needed to defendants. III(B)(6) (A 43-44).

mitted. The experts unanimously testified at trial that all encounters should be recorded in the individual medical record which should be available at all encounters.\* Moreover, defendants ignore their own claim that the lobby clinic notebooks are presently supposed to "provide, in part, a running summary of the treatment provided at the clinic to particular inmates as well as reminders to the nurse so that appropriate follow-up appointments may be scheduled" (Brief at 20 and 50). It is hardly an administrative burden or intrusion to require the staff\*\* to follow long-standing instructions of fundamental importance, albeit by inserting the information in a different and more relevant record.\*\*\*

\* The Judgment is in accord with accepted minimal correctional and health standards. See Association of State Correctional Administrators, Uniform Correctional Policies and Procedures, at ABA Compilation 41 ("complete and accurate records documenting all medical examinations, medical findings and medical treatment should be maintained at the institution under the supervision of the medical officer"); National Sheriffs' Association, Manual, supra, in ABA Compilation at 20 (all complaints of illness or injury should be noted on the prisoner's medical record together with treatment prescribed); National Advisory Committee on Criminal Justice Standards and Goals, Standard 2.6, in ABA Compilation, 16-17; American Public Health Association, Standards for Health Services in Correctional Institutions, 102-04 (1976); AMA, Standards for Accreditation, supra, 26-27; ABA, Standards, supra, 14 Crim.L.Rev. at 484-85.

\*\* Defendants assert, without the slightest evidentiary support, see Nadeau v. Helgemoe, 423 F.Supp. 1250, 1264 (D.N.H. 1976), that four nurses would be needed to dispense medication in order to record the screening encounter. Quite apart from the legal irrelevance of such a claim, see note at p. 76, supra, it is hard to see the need for such a vast increase in staff to perform a simply recording function already assigned to the existing staff.

\*\*\* Defendants' criticism of other record-keeping requirements is unfounded for similar reasons. Their objection to the doctor's appointment book, III(B)(9), as too "detailed" and inappropriate (Brief at 68) overlooks both their testimony at trial that they already maintain a doctors' appointment book (Appellants' Brief

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Further, the court found that the existing nurse staff had failed to perform minimally adequate medical evaluation at lobby clinic though long conducting what they believed was "screening."\* Consequently, to insure that the terms of the Judgment are fully and properly implemented, the Court reasonably directed that the screening nurses\*\* be provided with one time special training\*\*\* in the techniques required by the

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at 22; Defendants' Exhibit L), and the Court's finding that existing record-keeping has failed to insure that inmates receive doctors' appointment ordered for them. Also proper maintenance of an appointment record is essential to avoid the information and judgment gap shown at trial to exist when a staff member other than the screening nurse does the scheduling. This is particularly important since the District Court rejected plaintiffs' request that the screener do the scheduling on the spot. Compare Plaintiffs' Proposed Judgment III(B)(8)(A-56), with Judgment III(B)(8)(A 44-45).

Likewise, the requirements for a sick wing round record and laboratory order book, II(F) and IV(F), to which defendants objected, are simply directives for proper completion of records which defendants have long maintained.

\* See Memorandum in Support of Plaintiffs' Proposed Judgment, at 17.

\*\* Contrary to defendants' claim (Brief at 66), the requirement that screening be performed by staff with at least the training of a registered nurse does not preclude the use of, for example, a registered physician's assistant who has more training in and greater power to make diagnostic and prescriptive judgments. N.Y. Educ. Law, §§6540-47 (McKinney). Even that Bedford Hills has always employed registered nurses does not mean that the Judgment permits extensive (two-week) delays in access to a physician based solely upon the screener's decision, III(B)(8), the Court acted reasonably in not permitting less trained personnel to conduct screening.

\*\*\* The requirement of one-time special training in the performance of a particular task is certainly not in any sense a mandate to change Civil Service classification, as defendants suggest (Brief at 66). See also Milliken v. Bradley, 97 S.Ct. at 2755, affirming order requiring in-service training of teachers as part of a remedial order against racial discrimination.

Judgment.\*

Finally, with regard to lobby clinic, defendants most inappropriately criticize the provision (III (B)(8)) which permits their health staff to delay doctors' appointments for two weeks after screening. They claim this will destroy staff authority and "virtually remove all discretion." (Brief at 67). Yet, in permitting such extensive delays, which absent adequate screening would normally be considered unconstitutional\*\* and rejecting plaintiffs' far more stringent proposal\*\*\*the District Court was in fact deferring in significant respect not just to defendants' medical judgment but also to their administrative discretion. Moreover, in setting an outer time limit, the Court was simply giving meaning to defendants' own stated policy of permitting a woman to see a doctor if she insisted. (Brief at 20).

The terms of the Judgment relating to follow-up are similarly designed to rectify the systemic inadequacies in a reasonable

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\* Nor is it improper to direct the Facility Health Services Director to establish written screening protocols after this Judgment simply because he had previously issued some standing orders. The evidence showed that Dr. Williams' prior orders did not in any way reflect the limited operation of the lobby clinic. While defendants are correct that the prior orders were not themselves declared unconstitutional, it was entirely reasonable for the court to order the chief physician to reconsider his standing orders in light of the changes in screening procedures mandated by the Judgment. Most significantly, defendants overlook the fact that the Judgment in no way infringes on their medical discretion in deciding what should be in the protocols.

\* See cases cited at pp. 59-60 and 64, supra.

\*\*\*Plaintiffs had proposed that inmates be seen within 3 working days of screening (A- 56 ).



and unintrusive way.\* The provisions for appointment slips, for both laboratory tests and doctors' appointments, Judgment III(B)(8), IV(A) and (E), flow directly from the Court's express findings that lack of notice to inmates of such appointments was one of the major reasons that tests and examinations were not performed as ordered (A25,27-28). Given defendants' unfettered discretion in scheduling diagnostic tests and follow-up appointments and their substantial leeway under the Judgment in scheduling doctor's appointments after screening, they should not be heard to complain (Brief at 69) that emergencies may make fixed schedules somewhat more difficult. Similarly, the Judgment's provisions for notice to inmates of both normal and abnormal test results respond to the defects established at trial. The court found that laboratory tests are repeatedly not performed, not reviewed by a doctor and not followed up with appropriate care. Among the causes was the lack of notice to inmates and defendants' inability or unwillingness to change their notification procedures. By insuring that inmates receive notice of test results within a limited time, a provision itself admittedly not constitutionally required, the Court was simply building in a mechanism to insure that diagnostic tests are performed, reviewed and followed up, as constitutionally required.\*\* These provisions, of course, in no way interfere with defendants' discre-

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\* Incredibly, defendants object to the requirement in I(C) that a copy of all inspection reports concerning x-ray machines be provided to plaintiffs' counsel (Brief at 60-61). They assert that the provision covers dental x-ray machines, though they know that dental care is not in any way being adjudicated in this action (T5). They also complain of "an unnecessary administrative burden" in xeroxing a few reports, ignoring the provision's origin in a finding that defendants had for years ignored reports that they were improperly irradiating hundreds of women on a routine basis.

\*\* See Martinez Rodriguez v. Jimenez, 409 F.Supp. at 597, ¶16.

tion to decide which test results require follow-up, in what form and at what point in time.

The provisions concerning sick wing likewise conform reasonably to the findings. The District Court received substantial evidence that the structure, staffing and procedures in sick wing prevent both communication by inmates of their medical needs and observation by medical personnel. It heard expert testimony that defendants "are not providing the kind of medical coverage or the medical overview that is essential and presumably required when you place that person in the room in the beginning." (T583). It learned that the Joint Commission on Accreditation of Hospitals had already recognized in October 1973, the need for "a readily available and functioning nurse call mechanism." (Ex. 133). Finally, it heard the inmates' frightening tales of nighttime isolation and disregard. Not to have acted in light of this evidence would have been dereliction of duty. Accordingly, the Court directed, as defendants had proposed (A-65), that the solid doors at the end of the sick wing corridors be removed. Further it directed that the nurse's station be moved adjacent to sick wing, that all necessary emergency equipment and supplies be immediately accessible, that a mechanical call system be available to each patient and within the direct hearing of the nurse in the station, and that nurses make rounds at least every two hours during the evening and night. These simple measures were necessary to overcome the lack of communication and medical observation documented at trial.



Defendants completely distort the plain meaning of the Judgment in suggesting that major construction would be needed to provide the nurse's station near sick wing (Brief at 62-63). As plaintiffs noted when proposing the nurse's station to the District Court, the room across the lobby from the end of the sick wing corridor, which is presently the officer's station, could easily be used as the nurse's station without any structural changes. (Memorandum in Support of Plaintiffs' Proposed Judgment, at 10 ). In addition, plaintiffs expressly noted that if emergency equipment, which inmates and experts testified was not readily available to nurses when helping sick wing patients, could not be safely stored in or near sick wing, then defendants could simply direct that there be no locked door between the office where the nurse will be stationed and the closet where emergency supplies are presently located. (Id. at 12 ). Plaintiffs proposed a mechanical rather than a light call system because, in negotiations prior to the submission of proposed judgments, defendants had indicated that they thought a light system would be easier to ignore (Id. at 11n). Further, since a phone is already in the officer's station the nurse stationed there could easily receive and respond to emergency calls or health inquiries, while fulfilling the sick wing functions set forth in the Judgment.\*

Nurse rounds are needed in addition to a call system since the record is replete with instances of women having convulsive

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\* The Judgment, II(D), expressly contemplates that the medical staff member at the station will be called away on occasion, contrary to defendants' claim. (Brief at 63).

seizures, experiencing difficulty breathing, or becoming unconscious who clearly could not avail themselves of a call system, though in desperate need. Indeed, defendants' complaint is odd, since the requirement is for rounds every two hours, II (C)(2) (A-42), although the evidence showed that substantial problems had developed in far shorter periods and that experts generally employed continuous direct observation of infirm patients in open ward settings. Similarly, the requirement for doctor's rounds of sick wing on each working day is a direct response to the substantial evidence of serious delay in access to a doctor. See Martinez Rodriguez v. Jimenez, 409 F.Supp. at 597 ("Provision shall be made for daily visits to the [infirm] by a medical doctor for any inmate confined there who is unable to move to the doctors' consultation room"). Defendants' claim that nurse and doctor rounds are unnecessary, since inmates may be there for "nothing more than a common cold" (Brief at 63 and 64), is wholly unfounded. Defendants' chief physician explained that women are only placed in sick wing when they have high fever, abnormal breathing, are returning from hospitalization, have just experienced a convulsive seizure, or are suffering some other condition which the medical staff determines requires close medical observation and care. Moreover, the reduction of sick wing from 19 to 8 rooms after trial indicates that only the inmates at Bedford Hills most in need of medical observation and treatment will be in sick wing.\*

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\* For similar reasons, defendants' objection to the provision concerning patients locked in individual rooms, II (A) (A-41), is unfounded. The evidence showed that locking of rooms significantly

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Lastly, the District Court, having discovered serious deficiencies in defendants' ability to supervise and enforce their own program requirements, required a moderate form of monitoring. Significantly, the Court rejected plaintiffs' proposal for auditing by persons not in the employ of the Department of Correctional Services, Plaintiffs' Proposed Judgment V(B) (A-60), and eschewed more drastic remedies, such as the outside citizen monitoring committees employed in Pugh v. Locke and Palmigiano v. Garrahy.

Given the extensive and long-standing deficiencies in defendants' system, some regular review by "qualified personnel"\* was obviously necessary for the initial period of enforcement.\*\*

In sum, in every instance, the District Court avoided intrusive, burdensome, or expensive procedures. Rather it adapted its remedies to the physical structure, past practice and staffing patterns at Redford Hills. Wherever possible, it deferred

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increases the isolation in sick wing and hence the risk to patient health. Accordingly, the Court limited the instances when patients could be locked to essentially the same psychiatric and disciplinary exceptions which defendants had always employed, and required that a physician be consulted within a reasonable time to insure that such locking would not jeopardize health. In light of the increased risk in locking, the limited numbers locked in sick wing and the evidence that the medical problems experienced in locked rooms often preclude use of a call system, the Court acted reasonably in requiring more frequent nurse and correction rounds for these individuals.

\* The court even rejected plaintiffs' request that the auditing staff be subject to court approval, compare Plaintiffs' Proposed Judgment V(B) with Judgment V(B) (A-47, 60).

\*\* See American Public Health Association, Standards, supra, at 106-08 (requiring regular independent and internal audits of prison health care services); AMA, Standards, supra at 3 (requiring at least quarterly written review of prison health care program).

to defendants' medical and administrative discretion. In this light, defendants' complaints can only be viewed as dissatisfaction with the holdings of unconstitutionality, rather than clear proof of abuse of the discretion conferred by those holdings. Their objections to the Judgment must, accordingly, be rejected.

CONCLUSION

FOR ALL THE ABOVE-STATED REASONS, THE COURT  
SHOULD AFFIRM THE JUDGMENT IN ALL RESPECTS.

Dated: New York, New York  
September 19, 1977

Respectfully submitted,

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ELLEN J. WINNER  
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Attorneys for Plaintiffs-  
Appellees



UNITED STATES COURT OF APPEALS  
FOR THE SECOND CIRCUIT

-----X

LOUISE TODARO, et al., :  
Plaintiffs-Appellees, : 77-2095  
-against- : AFFIDAVIT OF  
BENJAMIN WARD, et al., : SERVICE  
Defendants-Appellants. :  
-----X

STATE OF NEW YORK )  
: SS.:  
COUNTY OF NEW YORK )

ELLEN J. WINNER, being duly sworn deposes and says:

1. I am a staff attorney of the Prisoners' Rights Project Legal Aid Society, Attorney for the Plaintiffs-Appellees in this case.

2. On September 19, 1977 I served the within appellees' brief and motion for permission to file an extended brief upon defendants by leaving true copies thereof at Two World Trade Center, New York, New York 10047, the office of the attorneys for defendants-appellants Louis J. Lefkowitz, Attorney General of the State of New York and Arlene R. Silverman, Assistant Attorney General.

*Michael D. Campbell*  
Sworn to before me this  
19th day of September, 1977

*Ellen J. Winner*  
ELLEN J. WINNER

L. B. AUSUBIN  
Notary Public, State of New York  
No. 31-2  
Qualified in New York County  
Commission Expires March 19, 1978

